

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07550

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Winchester				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 327 N. Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Phyllis	Middle Ann	Last ALDERMAN	4. DATE OF DEATH July 6, 1957	Month July	Day 21	Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6 July 1957	9. AGE (in years last birthday) 15 yrs.	IF UNDER 1 YEAR Months 15	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Verne H. ALDERMAN		14. MOTHER'S MAIDEN NAME Margaret RIDER						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Official Navy Records		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7544								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 7544								
(b) DUE TO Congenital Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Winchester		(County) Virginia (State) MD
21. I certify that I attended the deceased from 14 July , 19 57 , to 21 July , 19 57 , that I last saw the deceased alive on 21 July , 19 57 , and that death occurred at 5:50 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) LT(Cmc) J.W. Russell Miller Jr.						
ACTUAL SIGNATURE		DATE SIGNED 7-22-57						
PHYSICIAN'S NAME (Type) RUSSELL MILLER JR.		M.D. U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-24-57		22c. NAME OF CEMETERY OR CREMATORIUM Private Cemetery		22d. LOCATION (City, town, or county) Winchester, Virginia (State) VA		
23. FUNERAL DIRECTOR'S SIGNATURE Dorothy M. Bayard		ADDRESS Jones Funeral Home, Winchester, Virginia		24a. REC'D BY REGISTRAR Tharay E. Parrelly		24b. REGISTRAR'S SIGNATURE Tharay E. Parrelly		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician, it should be filed with page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CLASSIFIED BY THE DEPARTMENT OF DEFENSE

BUREAU V. S.

JUL 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07551
CERTIFICATE OF DEATH 216

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 51 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 51			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 8035 Eastern Avenue			
3. NAME OF DECEASED (Type or print)	First Robb	Middle French	4. DATE OF DEATH Allensworth July 24 1957		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1901	9. AGE (In years lost birthday) 56 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Kentucky	
13. FATHER'S NAME James B. Allensworth		14. MOTHER'S MAIDEN NAME Evie Robb		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. 214-34-7106		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 331X		2 hours			
(b) DUE TO Sub Dural Hemorrhage		2 days			
(c) DUE TO Acute Myelogenous Leukemia		5 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 3, 1957, to July 24, 1957, that I last saw the deceased alive on July 24, 1957, and that death occurred at 8:50 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Dane Boggs M.D.		ADDRESS (Street, city or town, state) The Clinical Center 25 July 1957			
PHYSICIAN'S NAME (Type) Dane Boggs, M.D.		National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/27/1957		22c. NAME OF CEMETERY OR CREMATORIAL George Wash. Memorial	
22d. LOCATION (City, town, or county) Prince Georges County, Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		24a. ADDRESS 2901 14th St., N.W. Washington 9, D.C.		24b. REC'D BY REGISTRAR DATE JUL 29 1957	
				REGISTRAR'S SIGNATURE Bessie Thompson	

CERTIFICATE OF DEATH

BUREAU Y.

JUL 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 2. It should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 0216 7-10-57 et
07595

07552

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Seneca		d. STREET ADDRESS R.F.D. Poolesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Partnership Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOSEPH	Middle N.	Last ALLNUTT	4. DATE OF DEATH July 10, 1957	Month Day Year 19		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 19, 1864	9. AGE (In years last birthday) 93	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 21	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (State or foreign country) Seneca, Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Benoni Allnutt		14. MOTHER'S MAIDEN NAME Emily Dawson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Guy F. Allnutt - RFD Poolesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia INTERVAL BETWEEN ONSET AND DEATH 491X 2 days DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. 4423 (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atherosclerotic Cardiovascular Renal Disease. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19 ⁵ to 10 July, 19 ⁵⁷ , that I last saw the deceased alive on 10 July, 1957 , and that death occurred at 6 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon M. Smith		ADDRESS (Street, city or town, state) Boyd's, Maryland DATE SIGNED 10 July 57					
PHYSICIAN'S NAME (Type) Gordon M. Smith - Boyd's, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/13/57		22c. NAME OF CEMETERY OR CREMATORIUM Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 7/12/57		24b. REGISTRAR'S SIGNATURE Chas. Clin	

CERTIFICATE OF DEATH

X

Death

Bronxville, Bronx County

Abstracts of Deaths Certified by Physician

BUREAU U.S.

e copy of
copy ofJuly 16, 1947
Death certificate

RECEIVED

e copy of
copy of

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07552

CERTIFICATE OF DEATH

17553
223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>WEST VIRGINIA.</i>		b. COUNTY <i>HARDY</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>7 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MOOREFIELD</i>		d. STREET ADDRESS <i>858-3</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Pamela</i>		First <i>P</i>	Middle <i>Rae</i>	Last <i>Arnold</i>	4. DATE OF DEATH <i>July 13 1957</i>	Month <i>July</i>	Day <i>13</i>	Year <i>1957</i>		
5. SEX <i>Girl</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-6-57</i>	9. AGE (In years from birthday) yrs. <i>7</i>	IF UNDER 1 YEAR Months <i>7</i>	IF UNDER 24 HRS. Days <i>4</i>	Hours <i>15</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>				
13. FATHER'S NAME <i>DONALD D. ARNOLD</i>		14. MOTHER'S MAIDEN NAME <i>EVELYN KATHLEEN KEMP</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>HOSPITAL RECORDS WASHINGTON SANITARIUM</i>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>754.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>(b)</i> DUE TO Congenital malformation of heart and great vessels <i>(c)</i> Two chambered heart & drainage of pulmonary veins into liver; Coarctation aorta, fetal type				INTERVAL BETWEEN ONSET AND DEATH <i>7 DAYS</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <i>7620 Nons</i>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. <input checked="" type="checkbox"/> p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1352 UNIVERSITY Lane</i>		20f. (City or town) <i>Moorefield, West Va.</i>		(County) <i>Moorefield</i>	(State) <i>West Va.</i>	
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>1352 UNIVERSITY Lane</i>			DATE SIGNED <i>7/13/57</i>	
ACTUAL SIGNATURE <i>Harold Sterling</i>		M.D. <i>1352 UNIVERSITY Lane</i>								
PHYSICIAN'S NAME (Type) <i>HAROLD STERLING</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-16-57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Olivet Cemetery</i>		22d. LOCATION (City, town, or county) <i>Moorefield, West Va.</i>		(State) <i>West Va.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Thrush Funeral Home</i>		ADDRESS <i>Moorefield, West Va.</i>		24a. REC'D BY REGISTRAR <i>16 1957</i>		24b. REGISTRAR'S SIGNATURE <i>J. Nelson Dodd</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Page 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED - LIBRARY OF THE STATE OF ILLINOIS - SPRINGFIELD

CERTIFICATE OF RECOGNITION

RECEIVED

JUL 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07554

Reg. Dist. No. 216

CERTIFICATE OF DEATH

07596

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chevy Chase

c. LENGTH OF STAY IN 1b
OR INSTITUTION

5 W. Melrose Street

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chevy Chase X

d. STREET ADDRESS

5 W. Melrose Street

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

ALEXANDER

First

Middle

Last

4. DATE
OF
DEATH

July 11,

1957

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

12/20/72

July

9. AGE (In years
lost birthday)

84 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret.

11. KIND OF BUSINESS OR INDUSTRY

Dep. Agriculture

12. BIRTHPLACE (State or foreign country)

13. CITIZEN OF WHAT COUNTRY?

Washington, D.C.

US

14. MOTHER'S MAIDEN NAME

Elizabeth Cox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Harriet P. Ashley-Item# 2

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		2 yrs.	
177X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Carcinomatosis	
DUE TO		7	
(b)		Metastatic carcinoma of prostate	
DUE TO		9 land.	
(c)		7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 1947, to July 11, 1957, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED
---	---------------------------------------	-------------

ACTUAL SIGNATURE	Stewart Clapp	M.D.	3921 Ingman St N.W. 7/11/57
PHYSICIAN'S NAME (Type)	Wash 15 D.C.	ADDRESS	

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Bur-Transit	7/13/57	Homestead Cemetery	Allegheny Co., Pennsylvania

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey	Bethesda, Maryland	DATE 7-13-57	Bevie M. Hembree

CERTIFICATE OF DESIGN

X X X X X X X X

X

BUREAU V. S.
RECEIVED
JUL 16 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07597

CERTIFICATE OF DEATH

Reg. Dist. No.

07555
276PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesdac. LENGTH OF STAY IN lb
77 days

d. NAME OF HOSPITAL (If not in hospital, give street address)

The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE Georgia

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
McRae

d. STREET ADDRESS

512 First Avenue

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
DoyleMiddle
LaFonLast
Avery4. DATE
OF
DEATHMonth
JulyDay
22,Year
19 57

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

April 24, 1928

9. AGE (In years
lost birthday)

29 yrs

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS

Days

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Salesman

10b. KIND OF BUSINESS OR INDUSTRY

Haberdashery

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ernest Wright

14. MOTHER'S MAIDEN NAME

Maggie Bell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown)

Yes

WW II & Korean

16. SOCIAL SECURITY NO

unknown

17. INFORMANT

The Medical Record

Address

The Clinical Center, Bethesda 14, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

100X

DUE TO

WIDESPREAD CARCINOMATOSIS

INTERVAL BETWEEN
ONSET AND DEATH
6 MOS.Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

LEFT RENAL CELL CARCINOMA

14 MOS

(c)

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from May 6, 1957, to July 22, 1957, that I last saw the deceased
alive on July 22, 1957, and that death occurred at 3:30 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

ACTUAL
SIGNATURE

Gurston Goldin

MD

The Clinical Center

DATE SIGNED
7/23/57PHYSICIAN'S
NAME (Type)

Gurston Goldin, M. D.

National Institutes of Health
Bethesda 14, Maryland22a. BURIAL, CREMATION,
REMOVAL (Specify)

Transit

22b. DATE THEREOF

7/23/57

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

Soperton, Georgia

23. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey-Bethesda, Maryland

ADDRESS

24a. REC'D BY REGISTRAR

(State)

DATE 7-23-67

24b. REGISTRAR'S SIGNATURE

Bevrie M. Thompson

W. A. D.

AL 25 1957

DELEI V E

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07556.

07593 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE Virginia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		d. STREET ADDRESS #2 Skyline Court		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First William	Middle (mn)	Last AXMAN	4. DATE OF DEATH July	Month July	Day 31	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8 March 1888	9. AGE (In years last birthday) 69 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Emil AXMAN			14. MOTHER'S MAIDEN NAME Anna BOENCH					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes			16. SOCIAL SECURITY NO WW-I&II		17. INFORMANT Sister, Mrs. Emma W. Jones (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			Acute Myocardial Infarction 1 day Atherosclerotic Heart Disease 10 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4. Hysteria			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none						
20c. TIME OF INJURY Hour a. m p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 30 July 1957, to 31 July 1957, that I last saw the deceased alive on 31 July 1957, and that death occurred at 6:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Paul Driezen M.D. U.S. Naval Hospital, Bethesda, Md. 7-31-57								
PHYSICIAN'S NAME (Type) Paul Driezen, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md. 7-31-57						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-2-57	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town or county) (State) Washington, D. C.				
23. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines	ADDRESS S.H. Hines, 2901 14th St., N.W. Washington, D.C.	24a. REC'D BY REGISTRAR DATE 7-31-57 24b. REGISTRAR'S SIGNATURE Theresa E. Pannell						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. L

Aug 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07557

07599

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		
c. LENGTH OF STAY IN b. 36 days			d. STREET ADDRESS 4223 30th Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Easton	Middle Leroy	Last Baldwin	4. DATE OF DEATH July 12, 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1879	9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Benton F. Baldwin			14. MOTHER'S MAIDEN NAME Anna W. Baldwin		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH					
Part I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Adenocarcinoma, colon, post op resection					
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Intrastatic carcinoma, Uterus?					
DUE TO					
(c) Retention cysts, both kidneys					
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Benign Prostatic Hypertrophy.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6, 1957 , to July 12, 1957 , that I last saw the deceased alive on July 12, 1957 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE <i>David L. Kinsey</i>		M.D.		DATE SIGNED 7/12/57	
PHYSICIAN'S NAME (Type) David L. Kinsey, M. D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-15-57		22c. NAME OF CEMETERY OR CREMATORIUM EBENEZER CEMETERY	
22d. LOCATION (City, town, or county) (State) Loudoun Co., Va.		24a. REC'D BY REGISTRAR 7-16-57		24b. REGISTRAR'S SIGNATURE Russell M. Thompson	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C.P. Isaacs, M. D.</i>		ADDRESS Arlington, VA.			
VS A15 (4) ISM 9/55		24c. DATE 7-16-57			

BUREAU Y. &

JUL 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07553

CERTIFICATE OF DEATH

07558

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District Of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park 12		c. LENGTH OF STAY IN 1b 55 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d. STREET ADDRESS 156 F St., SE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen Ramey		First	Middle	Last	4. DATE OF DEATH July 13 1957
5. SEX Female		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3-30-07	9. AGE (In years last birthday) 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hairdresser		10b. KIND OF BUSINESS OR INDUSTRY Beauty Salon		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Robert Marshall		14. MOTHER'S MAIDEN NAME Sarah Bowie		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT Hospital Records	
Address					
18. CAUSE OF DEATH [Enter only one cause line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Peritonitis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		<i>Ileal fistula</i>		3 weeks.	
(c) <i>Coccerumia of cervix</i>				2 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 13, 1957</i> to <i>July 13, 1957</i> , that I last saw the deceased alive on <i>July 13, 1957</i> , and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED <i>Lyle Williams, M.D.</i> <i>July 13, 1957</i>	
ACTUAL SIGNATURE <i>Lyle Williams, M.D.</i>		PHYSICIAN'S NAME (Type) <i>Lyle Williams, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-16-57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill</i>	
22d. LOCATION (City, town or county) <i>Silver Spring, Md.</i>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Leesman Wash. D. C.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>7-16-57</i>	
				24b. REGISTRAR'S SIGNATURE <i>Karen M. Thompson</i>	

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X.

JUL 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07600

CERTIFICATE OF DEATH

07559

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 88 days		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 9429 Locust Hill Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Ruth	Middle Esther	Last Ball	4. DATE OF DEATH July 20 1957	Month July	Day 20	Year 1957				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1893	9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS Days 21	12. Hours Min. 00 00				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Thomas Preston		14. MOTHER'S MAIDEN NAME Ellen Dent									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or date of service)		17. INFORMANT The Medical Record Address Not available The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Uterus with abdominal carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Acute perforation of stomach ulcer (terminal) DUE TO (c)											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)								
21. I certify that I attended the deceased from April 23, 1957 , to July 20, 1957 , that I last saw the deceased alive on July 20, 1957 , and that death occurred at 12:30pm , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center								DATE SIGNED 7/20/1957			
ACTUAL SIGNATURE Edward W. Moore		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland									
PHYSICIAN'S NAME (Type) Edward W. Moore											
22a. BUR AL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/22/1957	22c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven	22d. LOCATION (City, town, or county) (State) Montgomery Maryland								
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.		ADDRESS 7-23-57		24a. REC'D BY REGISTRAR Bea Thompson	24b. REGISTRAR'S SIGNATURE						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JUL 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07601

CERTIFICATE OF DEATH

07561

Reg. Dist. No.

216

1. PLACE OF DEATH o COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 30 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS 5603 Grosvenor Lane				
3. NAME OF DECEASED (Type or print) Carrie		First Carrie	Middle Ethel			
4. DATE OF DEATH Ballard		Month July	Day 18			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH March 14, 1891		9. AGE (In years last birthday) 66 yrs	10. IF UNDER 1 YEAR Months 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Owner		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) Kentucky			
13. FATHER'S NAME Pleasant M. Lanham		14. MOTHER'S MAIDEN NAME Julia Tramell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO Unascertainable	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH				
DUE TO <i>Respiratory arrest</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO <i>Pneumonia</i>						
(c) <i>Cerebral & renal anoxia</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form factory, street, office bldg., etc.) Corbin, Kentucky	20f. (City or town) Corbin	(County) Kentucky	(State) 15
21. I certify that I attended the deceased from June 18, 1957 , to July 18, 1957 , that I last saw the deceased alive on July 18, 1957 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.						
ADDRESS (Street, city or town, state) The Clinical Center, Bethesda 14, Md.						
DATE SIGNED 7-18-57						
ACTUAL SIGNATURE <i>Alexander N. Doudoumopoulos</i>						
PHYSICIAN'S NAME (Type) Alexander N. Doudoumopoulos, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/19/57	22c. NAME OF CEMETERY OR CREMATORIUM Ryan Cemetery	22d. LOCATION (City, town or county) Corbin, Kentucky		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR 7-19-57	24b. REGISTRAR'S SIGNATURE <i>Beacie M. Thompson</i>	

BUREAU V. S.

UL 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

(7602

CERTIFICATE OF DEATH

07561

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN lb 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Le Beau Gardens Rest Home				d. STREET ADDRESS 5118 301st St. N. E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) BESSIE		First	Middle	Last	4. DATE OF DEATH July 18, 1957
		ELLEN		BARBER	Month Day Year 19 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/29/1879	9. AGE (In years lost birthday) 77 yrs.	10. IF UNDER 1 YEAR Moths 11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Samuel Davis		14. MOTHER'S MAIDEN NAME Mary E. Phebus			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Wm. E. Barber same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X		DUE TO Generalized arteriosclerosis			
		DUE TO Diabetes mellitus			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Diabetic polyneuritis			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1957, to July 18 , 1957, that I last saw the deceased alive on July 18 , 1957, and that death occurred at 12:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Samuel L. Bageant, M.D. 5600 N.H. Ave. Washington, D.C.			
ACTUAL SIGNATURE Samuel L. Bageant		DATE SIGNED 7/28/57			
PHYSICIAN'S NAME (Type) Samuel L. Bageant		5600 N.H. Ave., Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/22/57		22c. NAME OF CEMETERY OR CREMATORIUM Salem Methodist	
22d. LOCATION (City, town, or county) Cedar Grove		(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Punshrey		ADDRESS Fatesca, Maryland		24a. REC'D BY REGISTRAR DATE 7-19-57	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UPFEAU V. S

ML 3 - 1551

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 17562 713	
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>2 minutes</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION, <u>Washington Sanitorium & Hospital</u>					d. STREET ADDRESS <u>1052 Rockville St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William</u>		First <u>None</u>	Middle <u>Bardell</u>	Last	4. DATE OF DEATH	Month <u>7</u>	Day <u>14</u>	Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>12-21-04</u>	8. AGE (In years last birthday) <u>52</u> yr.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>			11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George Bardell</u>					14. MOTHER'S MAIDEN NAME <u>Bessie Kashtaluk</u>					Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u> (If no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT <u>Washington Sanitorium & Hosp. Records</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7hrs</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE <u>RESPIRATORY FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>CORONARY THROMBOSIS & INFARCTION</u> DUE TO (c) <u>CIRRONARY INSUFFICIENCY</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NONE</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>1357 University Lane</u>		(County) <u>Baltimore</u>	(State) <u>Md.</u>		
21. I certify that I attended the deceased from <u>5/15/53</u> to <u>July 14, 1957</u> , that I last saw the deceased alive on <u>July 14, 1957</u> , and that death occurred at <u>11:20A.M.</u> from the causes and on the date stated above.										ADDRESS (Street, City or town, State) <u>1357 University Lane</u>	DATE SIGNED <u>7/14/57</u>
ACTUAL SIGNATURE <u>Donald J. Berlin</u>		M.D.									
PHYSICIAN'S NAME (Type) <u>Donald J. Berlin</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-16-57</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Rosedale</u>		22d. LOCATION (City, town or county) <u>Baltimore</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob J. Berlin, Jr.</u>					ADDRESS <u>2100 Eastern Pk.</u>		24a. REC'D BY REGISTRAR <u>JUL 16 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. Nelson Kelly</u>		

RECEIVED
FBI BUREAU

JUL 16 1957

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

87563

07603 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda, Md		d. STREET ADDRESS 4609 Windsor Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Ladimir	Middle Charles	Last Bartos	4. DATE OF DEATH	Month July	Day 26	Year 19 57		
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3 November 1897	9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lincoln, Nebraska		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Frank Bartos		14. MOTHER'S MAIDEN NAME Maria Blatny		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1917-1947		17. INFORMANT Bruce B. Bartos		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Glioma 199X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. the deceased was admitted to this hospital on		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) and that death		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that deceased died from 11 July 1957 to 26 July 1957 . That I last saw the deceased alive on 19 , and that death occurred at 4:39 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 27 July 1957					
ACTUAL SIGNATURE R. C. Thomas, M.D.		PHYSICIAN'S NAME (Type) R. C. Thomas, LT, MC, USNR		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/30/1957		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery		22d. LOCATION (City, town, or county) Arlington			
23. FUNERAL DIRECTOR'S SIGNATURE S. J. Hines		ADDRESS 2901 14th Street, N.W. WDC		24a. REC'D BY REGISTRAR 7/26/1957		24b. REGISTRAR'S SIGNATURE Mary E. Garrity			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician to FURNISH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3. It will be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

MAR 31 1957

REGELIVE

REGELIVE

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
07564
Reg. Dist. No. 216

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Montgomery	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) o STATE Maryland b COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8512 Hazelwood Drive	d. STREET ADDRESS 8512 Hazelwood Drive	e. IS RELIEF CNA AT HOME YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF (Type or print) CHARLES First B. Middle BAYLY Last	f. DATE OF DEATH July 26,	Month Day Year July 26, 1957				
3. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH March 19, 1882	9 AGE (In years and birthday) 75 yrs	10 IF UNDER 1 YEAR Months 4 Days 7 Hours 0 Min.	11 IF UNDER 24 HRS Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.	10b. KIND OF BUSINESS OR INDUSTRY Lawyer	11 BIRTHPLACE (State or foreign country) Ohio	12 CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME William Bayly	14. MOTHER'S MAIDEN NAME Mary Brann	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO None	17. INFORMANT Abby Bayly Item # 2	Address	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 1420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM AND DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH sudden						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 7/27/57			
EXAMINER'S NAME (Type) Frank J. Broschart	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BLR AL CREMATON REMOVAL (Specify) Burial	22b. DATE THEREOF 7/29/57	22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cem.	22d. LOCATION (City, town, or county) Rockville, Maryland	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey	ADDRESS Bethesda, Maryland	24a. REC'D BY REGISTRAR 7-27-57	24b. REGISTRAR'S SIGNATURE <i>Benji M. Thompson</i>			

BUREAU V. S.

JUL 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07565

Reg. Dist. No. 216

07605

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS Deleware St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6808 Deleware St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) IDA		First M.	Middle BEAGLE	4. DATE OF DEATH July 14,	Month	Day	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 16, 1887	P. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months 8	Days 28	IF UNDER 24 HRS. Hours 12
10a. USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) Ref. Govt. Emp.		10b. KIND OF BUSINESS OR INDUSTRY US Govt.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12 CITIZEN OF WHAT COUNTRY US	
13. FATHER'S NAME James V Beagle		14. MOTHER'S MAIDEN NAME Mary Roberts					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Lynda M. Beagle-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Carcinoma left breast with generalized metastases</i>				INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
<i>.70X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	DUE TO	(c)	DUE TO		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1835 Eye St., N.W.		20f. (City or town) (County) (State) Washington, D.C.	
21. I certify that I attended the deceased from May , 1947, to July 14 , 1952, that I last saw the deceased alive on July 13 , 1957, and that death occurred at 2:45 a.m. from the causes and on the date stated above							
ADDRESS (Street, city or town, state) Arnold McNitt M.D. 1835 Eye St., N.W. July 14							
DATE SIGNED Arnold McNitt Washington DC 1957							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/16/57		22c. NAME OF CEMETERY OR CREMATORIAL Rock Creek		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE 7-16-57	
						24b. REGISTRAR'S SIGNATURE Bessie M. Johnson	

BUREAU V. S.

JUL 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07566

07606

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		e. STREET ADDRESS X2 CHEVY CHASE 7017 MEADOW LANE	
3. NAME OF DECEASED (Type or print) BYRD		First	Middle
		Last	4. DATE OF DEATH JULY, 24,
5. SEX FEMALE		6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK (RETIRIED)		10b KIND OF BUSINESS OR INDUSTRY BANKING	8. DATE OF BIRTH AUGUST, 28, 1872
11. BIRTHPLACE (State or foreign country) MARYLAND		9. AGE (In years last birthday) 84 yrs	10. IF UNDER 1 YEAR Months 10 Days 26
12. CITIZEN OF WHAT COUNTRY? U.S.		11. IF UNDER 24 HRS Hours 1 Min. 0	
13. FATHER'S NAME SAMUEL RUFUS BELT		14. MOTHER'S MAIDEN NAME MARY RYLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	17. INFORMANT
		Address CHEVY CHASE, MD WILLIAM B. INGERSOLL 7017 MEADOW LANE,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
Right Cerebral Thrombosis, Severe Advanced generalised arteriosclerosis Essential Hypertension			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 44		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f. (City or town) 	(County) (State)
21. I certify that I attended the deceased from 1952 to July 24 , 1957, that I last saw the deceased alive on July 23 , 1957, and that death occurred at 4:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stewart Clapp		ADDRESS (Street, city or town, state) 3921 Ingomar NW • 7.24.57	
PHYSICIAN'S NAME (Type) Stewart Clapp		DATE SIGNED Wash 15 DC.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/26/57	
22c. NAME OF CEMETERY OR CREMATORIALy Perkins Chapel		22d. LOCATION (City, town, or county) Prince George Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR 7-24-57	
		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

HOSPITAL **ATTEND** **PHYSICIAN:** This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 9

JUL 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07607

CERTIFICATE OF DEATH

07566-14

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Capitol View</i>		c. LENGTH OF STAY IN 1b <i>unknown</i>		d. STATE <i>Maryland</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>HA DEAN GARDENS REST HOME</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		b. COUNTY <i>Montgomery</i>	
3. NAME OF DECEASED (Type or print) <i>John Peyton Bell</i>		First <i>John</i>	Middle <i>Peyton</i>	Last <i>Bell</i>	4. DATE OF DEATH <i>July 21 1957</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 2, 1892</i>	9. AGE (In years last birthday) <i>64 yrs</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman - Ret. Milk Company</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Washington, D.C.</i>		10c. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	
13. FATHER'S NAME <i>Temple Bell</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Kaiser</i>		12 CITIZEN OF WHAT COUNTRY: Address <i>8510 1/4th place</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Anna K. Oswiggle Hyattsville MD</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		<i>Coronary occlusion 2 min.</i> <i>Generalized arteriosclerosis 3 years</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on <i>July 12 1957</i> and that death occurred at <i>7:45 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>1919 Seminary Rd. 7-21-57</i>			
ACTUAL SIGNATURE <i>J. L. L. Rogers M.D.</i>		DATE SIGNED <i>7-21-57</i>			
PHYSICIAN'S NAME (Type) <i>JOHN S. ROGERS</i>		22a. BURIAL, Cremation, REMOVAL (Specify) <i>Cremation</i>			
22b. DATE THEREOF <i>July 24, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>George Washington</i>		22d. LOCATION (City, town, or county) <i>Prince George City Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. CHAMBERS CO.</i>		ADDRESS <i>O'Hearn Chapin St. N.W. Wash. D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>July 24, 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>Lorraine Miller</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07608

CERTIFICATE OF DEATH

07568

Reg. Dist. No. 216

M

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b Since 1941		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4513 Chase Avenue		d. STREET ADDRESS 4513 Chase Avenue	
3. NAME OF DECEASED (Type or print) Harriett Robert son		Last BLAKE	4. DATE OF DEATH July 25
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1886
9. AGE (In years at birthday) 70 yrs		10. IF UNDER 1 YEAR 7 Months	11. IF UNDER 24 HRS 19 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Schoolteacher		11. BIRTHPLACE (State or foreign country) Chicago, Illinois	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME S. H. Robertson	
14. MOTHER'S MAIDEN NAME Lucretia Robertson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Roland P. Blake-Same Item #2 - Husband	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 1 yrs	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c)		<i>Carcinoma of scutum</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1942 to July 25, 1952 that I last saw the deceased alive on July 25, 1957 , and that death occurred at 5301 1/2 M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4709 Montgomery Lane DATE SIGNED Bethesda, Md 7/26/57	
ACTUAL SIGNATURE <i>Paul D. Cantor, M.D.</i>		22d. LOCATION (City, town, or county) Prince Georges Maryland	
PHYSICIAN'S NAME (Type) Paul D. Cantor, M.D.		22e. BURIAL, CREMATION, REMOVAL (Specify) Cremation	
22f. DATE THEREOF 7/26/1957		22g. NAME OF CEMETERY OR CREMATORIUM Cedar Hill	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md		24a. REC'D BY REGISTRAR DATE 7-27-57	
ADDRESS Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

BUREAU V.

JUL 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3. It will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22a. 10-18 7/1957 cap

CERTIFICATE OF DEATH

Reg. Dist. No. **07569 216**

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Campbell	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lynchburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 322 Monroe St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Matthew	Middle James	Last Bolding	4. DATE OF DEATH Month July Day 18 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> March 13, 1932	9. AGE (In years lost birthday) 25 yrs.	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Furniture Store		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME William Bolding		14. MOTHER'S MAIDEN NAME Lillie Hendricks		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO Korean 224-34-6076		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2043		DUE TO Subarachnoid Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 30 min.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Acute Leukemia		(c)		5 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED White Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 13, 1957 to July 18, 1957 , that I last saw the deceased alive on July 18, 1957 , and that death occurred at 9:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Dane R. Boggs, M.D.					
ACTUAL SIGNATURE Dane R. Boggs		DATE SIGNED 7/19/57			
PHYSICIAN'S NAME (Type) Dane R. Boggs, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/21/57		22c. NAME OF CEMETERY OR CREMATORIUM White Rock Cemetery	
22d. LOCATION (City, town, or county) Lynchburg, Virginia					
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 901 3rd St., S. W.		ADDRESS JUL 22 1957		24e. REG'D BY REGISTRAR Bessie Thompson	
				24f. REGISTRAR'S SIGNATURE	

DECEMBER 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07610

CERTIFICATE OF DEATH

07570

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. LENGTH OF STAY IN 1b 20 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RuRal Norwood Rd., Silver Spring, M.		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Norwood Rd. Silver Spring, M.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Dennis		First A. Middle Boswell		4. DATE OF DEATH Month July Day 4 Year 1857				
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 30, 1866	9. AGE (in years from birth) 70 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Prince George Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Remus Noswell		14. MOTHER'S MAIDEN NAME Christy Lancaster						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Mary F. Boswell		Address 819 R. St., N. W. Wash. D. C.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Renal failure		INTERVAL BETWEEN ONSET AND DEATH				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) Anuria and Cardiac Decompensation		4 days				
DUE TO (c)		Chronic Nephritis with Hypertension		1946				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none						
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) RFD 1 Silver Spring, Md.	(County)	(State)			
21. I certify that I attended the deceased from 4/2/46 , 19, to 7/4/57 , 19, that I last saw the deceased alive on 7/3/57 , 19, and that death occurred at 3:45 PM , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Webster Sewell, M.D.</i>	ADDRESS (Street, city or town, state) RFD 1 Silver Spring, Md.		DATE SIGNED 7/11/57					
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/8/57	22c. NAME OF CEMETERY OR CREMATORIAL Good Hope	22d. LOCATION (City, town, or county) Colesville, M.	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snodder</i>		ADDRESS Rockville, Md.	24a. REG'D BY REGISTRAR DATE 7/11/57	24b. REGISTRAR'S SIGNATURE <i>James Gathen</i>				

BUREAU Y.
RECEIVED

JUL 11 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07571
216

Reg. Dist. No.

FOR STATE
HEALTH DERT.

M

If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN lb

D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

National Institutes of Health

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

July

Month

26

Day

19 57

Year

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED

DIVORCED

July 23, 1946

9. AGE (In years
last birthday)

11

yrs

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

None

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Ira B. Brittingham

14. MOTHER'S MAIDEN NAME

Anna May Carey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Hospital Record Address

The Clinical Center, Bethesda 14, Maryland

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Acute Lymphocytic Leukemia

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

None

with multiple petechial hemorrhages.

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY
Month, Day, Year
Hour o. m.
p. m.

20d. INJURY OCCURRED
While
at work Not while
of work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy Inspection , Inquiry , and in my opinion death resulted from Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

Frank J. Broschart

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S
NAME (Type)

Frank J. Broschart

DEPUTY MEDICAL EXAMINER

July 27, 1957

22a. BURIAL OR CREMATION
REMOVAL (Specify)

Burial 7/30/57

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

ADDRESS

22d. LOCATION (City, town or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Watson & Son Frankford Dela.

24a. REG'D BY REGISTRAR

DATE

24b. REG. STAR'S SIGNATURE

DATE

BUREAU A. S.

JUL 9 0 1937

REGELIVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 will be detached for use as the burial permit. Then please remove carbon papers. Pages 1 & 2 should be filed with
the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07612

CERTIFICATE OF DEATH

07572

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 6601 Glenbrook Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6601 Glenbrook Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Alfred	Middle T	Last Bronaugh	DATE OF DEATH July	Month 22	Day 19	Year 57
4. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/28/1872		9. AGE (in years last birthday) 85 yrs	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS Days 24
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Druggist		10b. KIND OF BUSINESS OR INDUSTRY own business		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John C. Bronaugh				14. MOTHER'S MAIDEN NAME Sallie C. Taylor		Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Alfred T. Bronaugh, Jr		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Respiratory failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO Pulmonary Infiltration (c) DUE TO Generalized lymphocytoma		
						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cachexia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20d. INJURY OCCURRED White	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from		April	1957	to	July 22	1957	that I last saw the deceased alive on	19 July 1957
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		12:10 P.M.		ADDRESS (Street, city or town, state) Suite 400, 8218 Wisconsin Ave		DATE SIGNED 7/22/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/25/57		22c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln		22d. LOCATION (City, town, or county) Suitland (State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Fumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR Date 7-28-57		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson		

BUREAU V. S.

JUL 9 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07573

(7555) CERTIFICATE OF DEATH

Reg. Dist. No. 773

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Montgomery Maryland</i>		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Takoma Park 3 yrs, Gales</i>		<i>Washington, D.C.</i>	
d. LENGTH OF STAY IN b.		d. STREET ADDRESS	
e. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>CEDAR HAVEN REST HOME</i>		3055 16th St. N.W. Apt. 504	
3. NAME OF DECEASED (Type or print)	First	Middle	4. DATE OF DEATH
<i>JANE</i>	<i>BROCKFIELD</i>	<i>BROWN</i>	<i>July 5 1957</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
<i>FEMALE white</i>		<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>MARCH 31, 1890</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>COLLEGE TEACHER TEACHING</i>		<i>NORTH CAROLINA</i>	12. CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>HENRY ALLEN BROWN</i>		<i>HARRIET BROOKFIELD</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
			<i>RECORDS</i>
			Address
			<i>CEDAR HAVEN REST HOME, Takoma Pk. Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
DUE TO			
<i>Cerebral Thrombosis</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>3 days.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b)			
DUE TO			
<i>Cerebral Arteriosclerosis - 9 years</i>			
C			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
4X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 3, 1957</i> to <i>July 5, 1957</i> that I last saw the deceased alive on <i>July 4, 1957</i> , and that death occurred at <i>9:58 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>Kenneth P. Campbell</i>		DATE SIGNED <i>July 8, 1957</i>	
PHYSICIAN'S NAME (Type) <i>Neil P. CAMPBELL</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/8/1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>S. H. Kline Co., Washington, DC</i>		ADDRESS <i>1111 16th St. N.W. Apt. 504</i>	
		24a. REGISTRY REGISTRAR <i>JULY 8 1957</i>	24b. REGISTRAR'S SIGNATURE <i>J. Wilson, Jr.</i>

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PEGEI V. S.

11 8 1957

PEGEI V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be referred to your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07574

2/18

1. PLACE OF DEATH ■ COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>		Reg. Dist. No							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>		c. LENGTH OF STAY IN TB <i>15 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Frederick Rd</i>		d. STREET ADDRESS <i>Frederick Rd</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <i>Josephine</i>		First <i>Jeanne</i>	Middle <i>Dol.</i>	4. DATE OF DEATH <i>July 10 1957</i>		Month <i>July</i>	Day <i>10</i>	Year <i>1957</i>					
5. SEX <i>Female</i>		COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DIVORCED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 1891</i>		9. AGE (In years last birthday) <i>65</i>	FUNDER YEAR Months <i>0</i>	IF UNDER 24 HRS Hours <i>0</i>	Min <i>0</i>				
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Joseph Brown</i>		14. MOTHER'S MAIDEN NAME <i>Eliza Lee</i>		Address <i>John E Brown - Gaithersburg MD</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Tel. no. or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>							
(If yes, give war or dates of service)						3 yrs							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>hypertension</i> DUE TO (c) <i>coronary occlusion</i>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>4444 X</i>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <i>at work</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Germantown</i>	(County) <i>Maryland</i>	(State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								DATE SIGNED <i>7-10-57</i>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		MD CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) <i>Frank J. Broschart</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
22a. BURIAL, CREMATION (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/13/57</i>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
22c. NAME OF CEMETERY OR CREMATORIUM ADDRESS <i>Brownstown Cemetery Rockville, MD</i>		22d. LOCATION (City, town, or county) <i>Germantown Maryland</i>											
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Gruber</i>		24a. REC'D BY REGISTRAR <i>JUL 17 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Alvilda Cook</i>									

BUREAU V. S.

NOV 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07614

CERTIFICATE OF DEATH

07575

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 42 dyas		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery					
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				e. STREET ADDRESS 12415 Coopers Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Walter		First Grant		Middle Burriss		4. DATE OF DEATH July 27		Month July	Day 27	Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/2/12		9. AGE (In years (last birthday) yrs. 70 yrs		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus driver		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Frank Burriss				14. MOTHER'S MAIDEN NAME Sarah Knight									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-16-2218		17. INFORMANT Hospital Admission Chrt		Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592 X		DUE TO Fracture		INTERVAL BETWEEN ONSET AND DEATH 2 months							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Chronic nephritis		(c)		10 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from June 1957 , to July 27, 1957 , that I last saw the deceased alive on July 27, 1957 , and that death occurred at 10 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Silver Spring, Md.		DATE SIGNED July 30, 1957									
ACTUAL SIGNATURE A. D. Bonyard		M.D. A. D. Bonyard											
PHYSICIAN'S NAME (Type) A. D. Bonyard													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 30, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Burtonsville Union Cemetery, Burtonsville, Mont. Co., Md.		22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE Warren G. Humphrey		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR 7-30-57		24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler							

BUREAU V

UG 5 1957

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G218 7/26/57 cap

07615

CERTIFICATE OF DEATH

07576

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb		b. COUNTY Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2010 Grace Church Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mabel E. Elizabeth Cash		First	Middle	Last	4. DATE OF DEATH July 22 1957
5. SEX F	6. COLOR OF RACE wh.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/1/1893	9. AGE (In years at last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife, beautician, cashier		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Texas	
13. FATHER'S NAME A. P. Griffith		14. MOTHER'S MAIDEN NAME Elizabeth Shaver		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT C.M. Cash 2010 Grace Ch.Rd., S.S., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		General Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary Artery Disease				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o.m. p.m. home 19.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1673 Park Road N.W.	20f. (City or town) Washington, D.C.	(County) (State)
21. I certify that I attended the deceased from February 1957 to July 22, 1957 , that I last saw the deceased alive on July 21, 1957 , and that death occurred at 1673 Park Road N.W. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 1673 Park Road N.W.	DATE SIGNED July 22, 1957
ACTUAL SIGNATURE James M. Loftus		PHYSICIAN'S NAME (Type) James M. Loftus			
22a. BURIAL OR CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/23/57	22c. NAME OF CEMETERY OR CREMATORIUM Forest Lawn Cemetery	22d. LOCATION (City, town, or county) Fort Worth, Texas	(State)
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.		ADDRESS Wash. DC	24a. REC'D BY REGISTRAR JUL 23 1957	24b. REGISTRAR'S SIGNATURE Frances Paffey	

U.S. 28 1957

RECEIVED

17577

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07616 CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. Gen. Hosp.				d. STREET ADDRESS 222 E. Diamond Ave.			
3. NAME OF DECEASED (Type or print)	First BESSIE	Middle BEALL	Last CASHELL	4. DATE OF DEATH	Month July	Day 5	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1879	9. AGE (In years last birthday) 77	10. IF UNDER 1 YEAR Months 9	11. IF UNDER 24 HRS. Days 17	12. IF UNDER 24 HRS. Hours Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Layhill, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hazel W. Cashell				14. MOTHER'S MAIDEN NAME Elizabeth Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Walter Plummer-33 Maryland Ave.		Address Gaithersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure INTERVAL BETWEEN ONSET AND DEATH 000.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- } (b) Uremia lying cause last } DUE TO (c) Chronic Pyelonephritis, Hypertension, Generalized Arter							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE 448 X (D) DUE TO 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 , to 7/15 , 1957, that I last saw the deceased alive on 7/15 , 1957, and that death occurred at 10:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Luciano L. Leal M.D. 108 N. Frederick Ave. DATE SIGNED ACTUAL SIGNATURE Luciano L. Leal							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/1957		22c. NAME OF CEMETERY OR CREMATORIUM Rockville Union		22d. LOCATION (City, town, or county) Rockville (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.				24a. REC'D BY REGISTRAR DATE 11/3 1957 24b. REGISTRAR'S SIGNATURE Esther Leal			

BUREAU Y.

JUL 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07617 CERTIFICATE OF DEATH

07578

Reg. Dist. No. 216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) b. STATE	
<i>Montgomery</i>		<i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Bethesda</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>German town</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>Joseph</i>	Last <i>Clements</i>
4. DATE OF DEATH	Month <i>7</i>	Day <i>8</i>	Year <i>1957</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-5-16</i>
9. AGE (In years from birth) <i>40 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Store keeper</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Merchant</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>William Joseph Clements</i>	14. MOTHER'S MAIDEN NAME <i>Pearl Selby</i>	Address <i>Germantown, Md</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Eleanor Clements</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4420.1</i> (b) <i>Anterior myocardial infarction</i> DUE TO (c) <i>Thrombosis Left Anterior Descending Coronary Artery</i> , 1 day
			INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>July</i>	Day <i>7</i>	Year <i>1957</i>
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>215 W Montgomery Ave Rockville, Md</i>	20f. (City or town) <i>Rockville</i>	(County) <i>Md</i>
21. I certify that I attended the deceased from <i>7-7</i> , 19 <i>57</i> , to <i>7-8</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>7-7</i> , 19 <i>57</i> , and that death occurred at <i>35 47 M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William G. Hall</i>	PHYSICIAN'S NAME (Type) <i>William G. Hall</i>	ADDRESS (Street, city or town, State) <i>215 W Montgomery Ave Rockville, Md</i>	DATE SIGNED <i>7/8/57</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-11-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Part Farm</i>	22d. LOCATION (CITY, TOWN, COUNTY) <i>Rockville</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest L. Gardner, Gaithersburg, Md</i>		ADDRESS <i>Ernest L. Gardner, Gaithersburg, Md</i>	24a. REC'D BY REGISTRAR DATE <i>7-10-57</i>
		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

BUREAU V. S

JUL 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07579

7556

CERTIFICATE OF DEATH

Reg. Dist. No. 223

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages d & e should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE WASH., D.C.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. SAN + HOSP		d. STREET ADDRESS 38 TUCKERMAN ST NW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) SIMON		First	Middle	Last	4. DATE OF DEATH COHEN	Month	Day	Year
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-15	9. AGE (In years last birthday) 42 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER - DELICATESSEN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ABRAHAM COHEN		14. MOTHER'S MAIDEN NAME ELIZABETH						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WWII ARMY		16. SOCIAL SECURITY NO.		17. INFORMANT Wife - Sarah Cohen 387 Webster		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.1		DUE TO myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 48 hrs.				
Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause lost. (b) CORONARY OCCLUSION DUE TO (c) ATHEROSCLEROSIS								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 115 -						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20f. (City or town) Falls Church, Va.		(County) Falls Church, Va. (State) VA
21. I certify that I attended the deceased from Nov , 19 55 , to 2-24 , 19 57 , that I last saw the deceased alive on 7-24 , 19 57 , and that death occurred at 7:25 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 1981 Eastern Ave Silver Spring, M.D.		DATE SIGNED 10/25/1957		
ACTUAL SIGNATURE Bernard L. Ostrow								
PHYSICIAN'S NAME (Type) Goldberg Funeral Home (Washington, D.C.)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/25-1957		22c. NAME OF CEMETERY OR CREMATORIUM National Memorial Park		22d. LOCATION (City, town, or county) Falls Church, Va.		(State) VA
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home (Washington, D.C.)		ADDRESS 1000 Rockville Pike, Bethesda, MD 20814		24a. REC'D BY REGISTRAR JUL 26 1957		24b. REGISTRAR'S SIGNATURE J. Wilson Dohle		

BUREAU V.

11 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07618

CERTIFICATE OF DEATH

07550

217

Reg. Dist. No.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part I may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. LENGTH OF STAY IN lb <i>9 hrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Chronic Hosp</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda x2</i>	
3. NAME OF DECEASED (Type or print) <i>NANNIE</i>		First <i>1</i>	Middle <i>2</i>
4. DATE OF DEATH <i>July 23 1957</i>		Lost <i>—</i>	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 27, 1862</i>
9. AGE (In years lost birthday) <i>95 yrs.</i>		10. IF UNDER 1 YEAR Months <i>3</i>	11. IF UNDER 24 HRS Days <i>26</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Alford, N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>M.S.H.</i>	
13. FATHER'S NAME <i>R. M. Mitchell</i>		14. MOTHER'S MAIDEN NAME <i>Virginia Anne Dorsey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>	
17. INFORMANT <i>Miss Virginia Collins</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, labor</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Cerebral vascular accident</i> (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs.</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>490X</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on <i>28 July 1957</i> , and that death occurred at <i>10:15 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>John M. Wyman</i> ADDRESS (Street, city or town, state) <i>7659 Old Georgetown Rd. Beth. Md</i> DATE SIGNED <i>7/1/57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/26/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Rock Creek</i>
22d. LOCATION (City, town, or county) <i>Washington, D.C.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 29 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>Gertude Lewellen</i>	

BUREAU V. S

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07619 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07582

Reg. Dist. No. 216

FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-travel permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

This certificate should be executed by the Chief Medical Examiner, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

1. PLACE OF DEATH a. COUNTY		MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		MARYLAND		d. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
c. LENGTH OF STAY IN TB		1 yr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Chevy Chase		d. STREET ADDRESS <u>3937 Narendale Rd</u>	
3. NAME OF DECEASED (Type or print)		First <u>THELMA</u> Middle <u>H.</u>		e. IS REC'D. FOR ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. SEX		6. COLOR OR RACE <u>Female</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH		9. AGE (in years at time of death) <u>55</u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Clerk</u> U.T.A.		11. BIRTHPLACE (State or foreign country) <u>Texas</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
Unknown		Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>Marion L. Compton (son)</u> <u>Ste. 2</u> <u>sudden</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO <u>4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20c. TIME OF INJURY Hour a.m. p.m.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 1P		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>FRANK J. Broschart</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7-28-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/30/57		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				24a. REC'D. BY REGISTRAR DATE 7-29-57	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

RECEIVED
MAY 1 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07620

CERTIFICATE OF DEATH

07583

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				b. COUNTY Montgomery				
c. LENGTH OF STAY IN 1b RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6921 Old Spring Road				d. STREET ADDRESS 6921 Old Spring Road				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First ESTHER	Middle V.	Last COOKMAN	4. DATE OF DEATH	Month July	Day 14	Year 1957
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1884	9. AGE (In years last birthday) 73	10. IF UNDER 1 YEAR Months 4	11. IF UNDER 24 HRS. Days 26	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Charles E. Vrooman				14. MOTHER'S MAIDEN NAME Julia French				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		None		Mrs Henry G. Herrell- Item # 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized cancer								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.								
(b) Cancer of Bladder								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Highly nervous reactions to hard life.								
INTERVAL BETWEEN ONSET AND DEATH Jan. 1956								
Jan. 1956								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. g. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
19								
21. I certify that I attended the deceased from 1952 , 19, to July 17 , 1957, that I last saw the deceased alive on July 11 , 1957, and that death occurred at 3 P.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state)								
DATE SIGNED								
Julie M. Green M.D.								
1726 Eustis N.W. Wash								
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 7/16/57	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		22d. LOCATION (City, town, or county) Suitland, Md.			
(State) D.C.								
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.								
ADDRESS								
24a. REC'D BY REGISTRAR DATE 7-16-57								
24b. REGISTRAR'S SIGNATURE Bessie M. L. Johnson								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registered prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y 5

JUL 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07621 CERTIFICATE OF DEATH

07584

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4902 Jamestown Road			d. STREET ADDRESS 4902 Jamestown Road		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First JEROME	Middle ROBERTS	Last DAVIS	4. DATE OF DEATH July 12, 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/13/87	9. AGE (In years lost birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 7 Days 29 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect		10b. KIND OF BUSINESS OR INDUSTRY Gov-Retired		11. BIRTHPLACE (State or foreign country) Wisconsin	
13. FATHER'S NAME George D. Davis		14. MOTHER'S MAIDEN NAME Fannie Roberts		12. CITIZEN OF WHAT COUNTRY? US	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Lucy G. Davis Same as #2	
				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Acute Coronary Insufficiency		INTERVAL BETWEEN ONSET AND DEATH 15 minutes	
		Coronary Heart Disease		11 years	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. g. 1957 p. m. —		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1955 to July 13, 1957, that I last saw the deceased alive on July 12, 1957, and that death occurred at 1:30 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Michael J. McInerney		ADDRESS (Street, city or town, state) 1150 Conn Avenue, Washington, D.C.		DATE SIGNED 7-12-57	
PHYSICIAN'S NAME (Type) Michael J. McInerney		1150 Conn Ave. Wash. D. C. 7-12-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/15/57		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery	
22d. LOCATION (City, town, or county) Rockville, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pursey, Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 7-13-57	
				24b. REGISTRAR'S SIGNATURE Basil M. Inerney	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUL 16 1957

BUREAU V. S.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy or death certificate assembly should be detached for use as a burial transit permit.

VS A150-155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 8&9 FilmG218 7/26/57 cap

07585

07622 CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH COUNTY CITY (If outside corporate limits, write RURAL OR TOWN TOWNE		MONTG	MARYLAND LENGTH OF STAY (In this place) 2MO	2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg. Rural	COUNTY Montg
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Montg, Co. General Hosp,			
3. NAME OF DECEASED (Type or Print)		(First) Maud	(Middle) Connelly	(Last) Davis	4. DATE (Month) (Day) (Year) OF DEATH July 14 19 57
5. SEX Female	6. COLOR OR White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Jan 12-18 ??	9. AGE last birthday 78 ?? yrs. Months 8 Days 2	IF UNDER 1 YEAR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Home Work	11. BIRTHPLACE (State or foreign country) Montg, Co. Md.		
13. FATHER'S NAME John Connelly		12. CITIZEN OF WHAT COUNTRY? U.S.A			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	14. MOTHER'S MAIDEN NAME Magaret Wolter		
			17. INFORMANT & ADDRESS Raymond Davis. Darnestown, Md.		
III DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		18. MEDICAL CERTIFICATION <i>Adenocarcinoma of Rectum 2 years</i>			
IV OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>June 18, 1957</u> , to <u>July 14, 1957</u> , that I last saw the deceased alive on <u>July 13, 1957</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Jack Brumback</u> M.D. ADDRESS (Street, city, town, state) <u>Gaithersburg, Md 20878</u> DATE SIGNED <u>8-15-57</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-16-57	NAME OF CEMETERY OR CREMATORIUM Darnestown Cemetery	LOCATION (City, town, or county) Darnestown. Md., (State)	
24. REC'D BY REGISTRAR DATE 7/16/57		REGISTRAR'S SIGNATURE <i>Ernest C. Gartner</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ernest C. Gartner. Gaithersburg. Md.		

1 23 1957

DECEIVED

SEARCHED SERIALIZED INDEXED FILED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07557

CERTIFICATE OF DEATH

07558
223

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>2 hours 11 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		d. STREET ADDRESS <i>201 Lincoln Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>First Charles Lee Middle Dennis, Jr. Infant Boy</i>		4. DATE OF DEATH <i>July 2, 1957</i>		Month July		Day 2	
5. SEX <i>Boy</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> July 2, 1957</i>		9. AGE (In years last birthday) yrs <i>2</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Lee Dennis</i>		14. MOTHER'S MAIDEN NAME <i>Mary Grace Coryell</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>—</i>		17. INFORMANT <i>Mother</i>		(See birth Cert.)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		Prematurity.		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8:30 am - 7-2-57</i> , to <i>9:30 AM - 7-2-57</i> , that I last saw the deceased alive on <i>7-2-57</i> , 19 <i>57</i> , and that death occurred at <i>621/4</i> A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)				DATE SIGNED	
ACTUAL SIGNATURE <i>Ruth Standard</i>		M.D.		Physician's Name <i>Ruth Standard, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>July 3, 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Washington Sanitarium & Hosp. Takoma Park, Maryland</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Hare, M. D. Takoma Park, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>JUL 5 - 1957</i>		24b. REGISTRAR'S SIGNATURE <i>J. Wilson Dell</i>	

BUREAU V. S.

MAY 8 1957

REGISTRATION
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07587

07623

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 2022 Columbia Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Minnie	Middle Viola	Last DICKINS	4. DATE OF DEATH July 23 1957	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 June 1867	9. AGE (In years from last birthday) 90 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Mississippi	
13. FATHER'S NAME Dudley A. STINSON			14. MOTHER'S MAIDEN NAME Nannie TARKINGTON		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) DUE TO Arterosclerotic Cardiovascular Disease					
INTERVAL BETWEEN ONSET AND DEATH 4 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of left femur, ft hip					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) ft. fell on floor of home			
20c. TIME OF INJURY Month Day Year Hour o.m. 7 p.m. 7/8 1957		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Washington		(County) D.C.		(State)	
21. I certify that I attended the deceased from 8 July 1957 , to 23 July 1957 , that I last saw the deceased alive on 23 July 1957 , and that death occurred on 12:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 7-24-57					
ACTUAL SIGNATURE George F. Risi PHYSICIAN'S NAME (Type) Dr. George F. RISI, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-26-57		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery	
22d. LOCATION (City, town or county) Arlington, Virginia		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines Co.		ADDRESS S.H. Hines, 2901 14th St., N.W. Washington, D.C.		24a. REC'D BY REGISTRAR 7-24-57	
				24b. REGISTRAR'S SIGNATURE Mary E. Farrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the register, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. John Ball, Assistant Medical Examiner, Montgomery Co., Md., Notified.

IRÉAU V.

LL 25 1957

DECEIVE

**FOR STATE
HEALTH DEPT.**

TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2 '57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07588

07621 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)		
a. COUNTY Montgomery				a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN MD 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10,205 Lorain Avenue		d. STREET ADDRESS 10,205 Lorain Avenue		e. IS PERSON ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Edward Joseph Donahue		First	Middle	DATE OF DEATH Julv 10, 1957	Month Day Year Month Day Year	
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH May 24, 1887	9. AGE (in years last birthday) 70 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.		11. BIRTHPLACE (State or foreign country) Proctor, Vt.		
13. FATHER'S NAME James F. Donahue		14. MOTHER'S MAIDEN NAME Margaret Kelly		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW #1		17. INFORMANT Edward C. Donahue, Kemp Mill Rd., Silver Spring		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Address (Md.)				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion				
DUE TO Conditions, if any, which gave rise to immediate cause (b)						
(a), stating the underlying cause lost. (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)		INTERVAL BETWEEN ONSET AND DEATH sudden				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Frank J. Proschart	EXAMINER'S NAME (Type) Frank J. Proschart			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED July 11, 1957	
22a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/13/57	22c. NAME OF CEMETERY OR CREMATORIUM PARKLAWN CEMETERY			22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MD.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Warren S. Lumphrey		ADDRESS SILVER SPRING, MARYLAND		24a. REC'D BY REGISTRAR Frances (Stoller)		24b. REC'D BY REGISTRAR'S SIGNATURE Frances (Stoller)

BERNARD V. S.

44-1121

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3. It should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07589

07588

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH a. COUNTY <i>Pennsylvania</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Pennsylvania</i>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN 1b <i>2 yrs 7 mo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pittsburgh</i>		d. STREET ADDRESS <i>825 Moorwood Avenue</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Chestnut Lodge, Inc.</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Mary Snyder</i>		First	Middle	Last	4. DATE OF DEATH <i>July 4</i>	Month	Day	Year <i>1957</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 31, 1891</i>		9. AGE (In years lost birthday) <i>66 yrs</i>	10. IF UNDER 1 YEAR Months <i>3</i>	11. IF UNDER 24 HRS Days <i>4</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>		
13. FATHER'S NAME <i>William Penn Snyder</i>		14. MOTHER'S MAIDEN NAME <i>Mary C Blaize</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hospital Records, Chestnut Lodge</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>mesenteric Thrombosis</i> INTERVAL BETWEEN ONSET AND DEATH DUE TO <i>410 X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Rheumatic Heart Disease</i> <i>35 yrs</i> DUE TO <i>with Mitral Stenosis and</i> (c) <i>anterior papillary muscle</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>104 S Washington St., Rockville, Md.</i>		20f. (City or town) <i>Pittsburg, Pa.</i> (County) <i>Pittsburg, Pa.</i> (State) <i>Pittsburg, Pa.</i>		
21. I certify that I attended the deceased from <i>July 4, 1957</i> , to <i>July 4, 1957</i> , that I last saw the deceased alive on <i>July 4, 1957</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Corinne Cooper</i> ADDRESS (Street, city or town, state) <i>104 S Washington St., Rockville, Md.</i> DATE SIGNED <i>July 4, 1957</i>								
PHYSICIAN'S NAME (Type) <i>Corinne Cooper - 104 S. Washington St., Rockville, Maryland</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bur-Transit</i>		22b. DATE THEREOF <i>7/8/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Allegheny Cemetery</i>		22d. LOCATION (City, town, or county) <i>Pittsburg, Pa.</i> (State) <i>Pittsburg, Pa.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Maryland</i>				ADDRESS		24a. REC'D BY REGISTRAR DATE <i>JULY 8 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>	

YUREAU V. S

11-8 1957

REGIYED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09644
223

(7558)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>3 hours 51 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>				d. STREET ADDRESS <i>313 University Blvd. E.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Infant Boy</i>		First	Middle	last	4. DATE OF DEATH <i>July 31, 1957</i>	Month	Day	Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 31, 1957</i>	9. AGE (In years from birthday) yrs. <i>3</i>	IF UNDER 1 YEAR Months <i>3</i>	IF UNDER 24 HRS. Days <i>56</i>	Hours Min. <i>56</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? Address <i>Phyllis Elizabeth Mellinger</i>		
13. FATHER'S NAME <i>Louis Robert Dreyer</i>			14. MOTHER'S MAIDEN NAME <i>Phyllis Elizabeth Mellinger</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO.			17. INFORMANT		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity (6 mo.)</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6:55 PM - 7-31-57</i> , to <i>7-31-57 - 10:45 PM</i> , that I last saw the deceased alive on <i>7-31-57</i> , 19 <i>57</i> , and that death occurred at <i>10:45 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Wash. San & Hosp.</i> DATE SIGNED <i>Ruth Standard M.D.</i>								
ACTUAL SIGNATURE <i>Ruth Standard</i>		PHYSICIAN'S NAME (Type) <i>Ruth Standard M.D.</i>		22d. LOCATION (City, town, or county) (State) <i>Takoma Park Md.</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>8-4-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Washington Sanitarium and Hosp., Takoma Park 12, D.C.</i>		22d. RECEIVED BY REGISTRAR DATE <i>1957</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Hare, M.D.</i>		ADDRESS <i>and Hosp., Takoma Park, Md.</i>		24d. REGISTRAR'S SIGNATURE <i>Gibson</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
LIBRARY X. E

AUG 12 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

075961

214

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) c. STATE d. COUNTY	
<i>Montgomery MARYLAND</i>		<i>8925 1/2 acre Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Silver Spring</i>		<i>SILVER SPRING</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>8925-1st ave</i>		<i>8925-1/2 acre</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>WILLIAM W. DUDLEY</i>		<i>W.</i>	<i>DUDLEY</i>
5. SEX	6. COLOR OR FACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<i>Male</i>			<i>Sept. 29, 1885</i>
9. AGE (in years from birthday) yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
<i>71</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
<i>Electrical Contractor</i>		<i>Takoma Park, Md.</i>	
12. CITIZEN OF WHAT COUNTRY?			
		<i>U. S. A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Frederick E. Dudley, Sr.</i>		<i>Betsy Cora Wentworth</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
		<i>None</i>	
17. INFORMANT		<i>Mrs F. Dudley, 8925 1/2 acre</i>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Chronic cardiac failure</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		<i>Obstruction of coronary vessels 2 years, respiratory chronic bronchitis</i>	
(b) DUE TO		<i>Obstruction of coronary vessels 2 years, respiratory chronic bronchitis</i>	
(c)		<i>Obstruction of coronary vessels 2 years, respiratory chronic bronchitis</i>	
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		<i>None</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. PLACE OF INJURY (Home, farm, 20e. (City or town) factory, street, office, bldg., etc.) (County) (State)	
<i>July 17, 1957 19</i>		<i>8922 Georgia Ave., Silver Spring, Md.</i>	
21. I certify that I attended the deceased from <i>July 17, 1957</i> to <i>July 17, 1957</i> , that I last saw the deceased alive on <i>July 17, 1957</i> , and that death occurred at <i>5 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>8922 Georgia Ave., Silver Spring, Md.</i> DATE SIGNED <i>7/17/57</i>	
ACTUAL SIGNATURE <i>John F. Harrington</i>			
PHYSICIAN'S NAME (Type) <i>John F. Harrington</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 19, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Suitland, Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer G. Humphreys</i>		24a. REC'D BY REGISTRAR DATE <i>7/23/57</i>	
ADDRESS <i>Silver Spring, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Frances Potter</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Loge 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

JUL 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07591

(7626) CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) b. STATE West Virginia										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN b. 12 days		c. CITY OF TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg										
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1017 West King Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)	First George	Middle Francis	Last Dunham	4. DATE OF DEATH July 13, 1957	Month Year	Day	Year							
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 20, 1902	9. AGE (In years lost birthday) 55 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min 0						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY Textile Mfg.		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.								
13. FATHER'S NAME Samuel R. Dunham				14. MOTHER'S MAIDEN NAME Anne McCarroll										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service) Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) (c) DUE TO Central nervous system								INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) New Brunswick		(County) New Jersey		(State) 0				
21. I certify that I attended the deceased from July 5, 1957 , to July 13, 1957 , that I last saw the deceased alive on July 13, 1957 , and that death occurred at 10:25 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Glenn A. Drager</i> M.D.								ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland					DATE SIGNED 7/14/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 7/15/57		22c. NAME OF CEMETERY OR CREMATORIUM St. Peters		22d. LOCATION (City, town or county) New Brunswick		(State) New Jersey						
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE 7-16-57		24b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>						

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
 it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JUL 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07592
(7627) CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 53 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS 7725 Brookville Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Emma	Middle Rebecca	Last Dunlop	4. DATE OF DEATH	Month July	Day 17	Year 19 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1910	9. AGE (In years last birthday) 47 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 3	12. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Maryland		12. CIT. ZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Horace E. Troth, Jr.				14. MOTHER'S MAIDEN NAME Grace E. Harr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO 577-07-2088		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>Recurrent anaplastic carcinoma of epiglottis with widespread metastases 15 mos</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hemorrhage - cystitis</i>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING () OR CONTRIBUTING () CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>ADDRESS (Street, city or town, state)</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 25 , 19 57 , to July 17 , 19 57 , that I last saw the deceased alive on July 17 , 19 57 , and that death occurred at 6:05 PM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Samuel Charache</i> M.D. The Clinical Center PHYSICIAN'S NAME (Type) Samuel Charache M.D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/19/1957		22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.				ADDRESS <i>Beesie M Thompson</i>		24a. REC'D BY REGISTRAR DATE 7-19-57	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 22 1957

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7 b-15-5-28
07628 CERTIFICATE OF DEATH

07593
214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 23 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 14,716 Colesville Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14,716 Colesville Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Cletus		First	Middle	Last	4. DATE OF DEATH Dwyer	Month	Day	Year
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1885		9. AGE (In years at birthday) 72 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Carpenter (retired)		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13. FATHER'S NAME Thomas Dwyer		14. MOTHER'S MAIDEN NAME Mary Trout						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-03-9766		17. INFORMANT Mrs. Erma L. Dwyer, 14,716 Colesville Rd., SS. Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxic Myocarditis DUE TO 501X						INTERVAL BETWEEN ONSET AND DEATH 1 day		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Traheo-Bronchitis						2 days		
(c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour 6. 31. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20f. (City or town) Sandy Spring		(County) (State)
21. I certify that I attended the deceased from 7/3/1957 to 7/23/1957 , that I last saw the deceased alive on 7/23/1957 , and that death occurred at 10:15 M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Sandy Spring		
ACTUAL SIGNATURE J. W. Bird						DATE SIGNED 7/24/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 26, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Colesville Cemetery		22d. LOCATION (City, town, or county) Colesville, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 7/25/57		24b. REGISTRAR'S SIGNATURE Frances J. ...		

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 29 1957

RECEIVED

U. S.

Mr. Danner, TV, AT&T Communications Dept.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07594

FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health.
 or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No.				
		07629														
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)														
a. COUNTY		b. STATE Maryland					c. COUNTY Montgomery									
Montgomery																
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
Silver Spring		2½ yrs.					Silver Spring									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS					e. IS RESIDENCE ON A FARM?									
901 Pershing Drive		901 Pershing Drive					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First		Middle			Lost		4. DATE OF DEATH		Month Day Year					
Eugene Emil Dzenis									July 21		19 57					
5. SEX		6. COLOR OR RACE		7. MARRIED			8. DATE OF BIRTH		9. AGE (In years to nearest month)		IF UNDER 1 YEAR IF UNDER 24 HRS					
male		white		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			Feb. 20, 1884		73 yrs		Months Days Hours Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?							
Caretaker		Office Building		Latvia					Latvia							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME														
David Dzenis		Emma Zeewald														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address										
No		228-42-3931		Mrs. Margaret Freevalds, 7329 Blair Rd., N. W.												
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]																
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO _____																
Conditions, if any, which gave rise to immediate cause (b) _____																
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____																
INTERVAL BETWEEN ONSET AND DEATH 5 months																
19. WAS AUTOPSY PERFORMED?																
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)														
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)						
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <i>John G. Ball</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											DATE SIGNED 7/21/57			
EXAMINER'S NAME (Type) John G. Ball																
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF July 24, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery					22d. LOCATION (City, town, or county) Washington, D. C.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Lorraine E. Lumpkin		ADDRESS Silver Spring, Md.											24a. REC'D BY REGISTRAR DATE 7-25-57		24b. REGISTRAR'S SIGNATURE Frances Ball	

BUREAU V. S

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07630

CERTIFICATE OF DEATH

07595

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE	
<i>Montgomery</i> MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>2236 Washington Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Charles Edward Edgar</i>		4. DATE OF DEATH Month Year	Day Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 14/57</i>
10a. USUAL OCCUPATION (Give kind of work done during most at working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) <i>Md.</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Barry Edgar</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Father</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral Fetal Atlectasis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>11 hours</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>752.5</i>			
(b) <i>Prematurity</i>			
(c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>4145 W. Rockland Rd.</i>
20f. (City or town) <i>Arlington</i>		(County) <i>Arlington Co.</i> (State) <i>Va.</i>	
21. I certify that I attended the deceased from <i>14 July 1957</i> to <i>18 July 1957</i> that I last saw the deceased alive on <i>14 July 1957</i> , and that death occurred at <i>4145 W. Rockland Rd.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Arlington Co., Va.</i> DATE SIGNED <i>7-19-57</i>			
ACTUAL SIGNATURE <i>John W. Rockland</i>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/17/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington Nat.</i>	22d. LOCATION (City, town, or county) <i>Arlington Co.</i> (State) <i>Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry Chapman Funeral Home</i>		ADDRESS <i>5706 3rd Street N.W.</i>	24a. REC'D BY REGISTRAR DATE <i>Bessie M. Thompson 7-19-57</i>
			24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
 page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar.

BUREAU V. S.

JUL 22 1957

REGELVÉD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C 7631 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07596

Reg. Dist. No. 21

FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 3 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 1010 Dale Drive		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1010 Dale Drive				e. DATE OF DEATH July 24		e. IS OR CRATE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Irene Pope Edwards		First	Middle	Last	Month	Doy	Year	
4. SEX female		5. COLOR OR RACE white	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. DATE OF BIRTH Dec. 1, 1909	8. AGE (in years last birthday) 47 yrs	9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS Days 0	11. IF UNDER 24 HR Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trained Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. PLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Carson Wesley Pope		14. MOTHER'S MAIDEN NAME Amy E. Bolt						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO 212-32-1208		17. INFORMANT Philip G. Edwards, 1010 Dale Drive, S. S., Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stealing the underlying cause lost. (b) DUE TO (c)				<i>asphyxiation Carbon Monoxide.</i>		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) inhaled exhaust fumes of AUTO						
20c. TIME OF INJURY Hour a. m. 12:30 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House		(County)		(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G. Ball</i>		EXAMINER'S NAME (Type) John G. Ball		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 24 July 67		
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF July 26, 1957		22c. NAME OF CEMETERY OR CREMATORIUM ADDRESS Rockville Cemetery Silver Spring, Md.		22d. LOCATION (City, town, or county) Rockville, Montg. Co., Md.		
22e. FUNERAL DIRECTOR'S SIGNATURE Warren C. Humphrey				22f. REC'D BY REG STRR Kobay		22g. REGISTRAR'S SIGNATURE Frances Peltier		
VS A155 SM 2 57								

BUREAU X-1

JUL 31 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The better copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07597

Reg. Dist. No... 77

07559 CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Montgomery	MARYLAND	STATE D. C.	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Takoma Park		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 517 Albany Avenue Oak Haven Rest Home		STREET ADDRESS (If rural give location) 717 Rittenhouse St. N. W.	
3. NAME OF DECEASED (Type or Print) Mary Mabel Eppley		4. DATE (Month) OF DEATH July 26, 1957	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1/26/1886
9. AGE last birthday 71 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Daniel Sullivan		14. MOTHER'S MAIDEN NAME Mary E. Shepherd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS Roland Park Apts. Wm. Dennis Sullivan-Baltimore, Md.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Carcinomatosis, generalized ANTECEDENT CAUSES (B) DUE TO Carcinoma of the generative organs. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerosis, generalized			
19a. DATE OF OPERATION 4/5/50		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 mo.	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 19, 1950, to July 26, 1957, that I last saw the deceased alive on 7-25-57, 19..., and that death occurred at 3:30 PM, from the causes and on the date stated above. SIGNATURE <i>A. Williamson</i> M.D. ADDRESS (Street, city, town, state) <i>240 Missouri Ave. N.W. Washington 11, D.C.</i> DATE SIGNED <i>1957</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/29/57	
24. REC'D BY REGISTRAR DATE <i>JULY 29 1957</i>		NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	
REGISTRAR'S SIGNATURE <i>J. Nelson Soddy</i>		LOCATION (City, town, or county) Prince Georges Co. Md.	
		25. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D.C.	
		ADDRESS	

RECEIVED
BUREAU V.

JUL 29 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 4 & 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07632

CERTIFICATE OF DEATH

07598

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle AUGUSTUS	Last FINCH
4. DATE OF DEATH JULY 17 1957	Month JULY	Day 17	Year 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH SEPT., 22, 1884
9. AGE (in years last birthday) 72 yrs	10. IF UNDER 1 YEAR Months 72	11. IF UNDER 24 HRS Days 0	12. Hours 0
13. FATHER'S NAME JAMES D. FINCH	14. MOTHER'S MAIDEN NAME EMMA B. FITNAM		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. -----	17. INFORMANT ELEANOR H. FINCH	Address 4000 VIRGILIA ST.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 13 days			
420.0 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis 13 days			
(c) Arteriosclerotic heart disease years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Bronchitis pneumonia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 4630 Montgomery Ave., Bethesda, Md.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 5, 1957 to July 17, 1957 , that I last saw the deceased alive on July 16, 1957 , and that death occurred at 1:28 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert N. Coale	ADDRESS (Street, city or town, state) 4630 Montgomery Ave., Bethesda, Md. DATE SIGNED July 17, 1957		
PHYSICIAN'S NAME (Type) Robert N. Coale			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/20/57	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey Bethesda, Maryland	ADDRESS	24a. REC'D BY REGISTRAR Dates 7-19-57	24b. REGISTRAR'S SIGNATURE Desiree M. Thompson

BUREAU V. S.

May 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07560

CERTIFICATE OF DEATH

07591

Reg. Dist. No.

723

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>123 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		d. STREET ADDRESS <i>18629 Piney Branch Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Eryva</i>		First <i>Estelle</i>	Middle <i>Fishback</i>	Last <i></i>	4. DATE OF DEATH <i>July 12 1957</i>	Month <i>July</i>	Day <i>12</i>	Year <i>1957</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/22/85</i>	9. AGE (In years last birthday) <i>72 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>	12. IF UNDER 24 HRS Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Williams B. Jenkins</i>		14. MOTHER'S MARRIED NAME <i>Catherine M. Creek</i>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Chart - Hospital Record</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>3IX</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Massive cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH <i>90 min.</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Post op - hip fracture - general debility - operation 5-12-57</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>		(County) <i></i> (State) <i></i>
21. I certify that I attended the deceased from alive on <i>July 12 1957</i> , and that death occurred at <i>9:30 PM</i> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>James R. Coleman, MD</i>		ADDRESS (Street, city or town, state) <i>113 Carroll St. NW Washington 12 DC</i>		DATE SIGNED <i>7/12/57</i>				
PHYSICIAN'S NAME (Type) <i>JAMES R. COLEMAN</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/15/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Ft. Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) <i>Prince Georges County, Md.</i>		(State) <i></i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. P. H. Hales Co</i>		ADDRESS <i>2901-14 S. L. N. W.</i>		24a. REC'D'DY REGISTRATION DATE <i>16 1957</i>		24b. REGISTRAR'S SIGNATURE <i>J. Helen Dodd</i>		

TO HOSPITAL OR PRACTICING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

JUL 16 1957

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07633 CERTIFICATE OF DEATH

Reg. Dist. No. **216**

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 50 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY Norfolk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Portsmouth		d. STREET ADDRESS 747 Commerce Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lucy	Middle Etta	Last Fisk	4. DATE OF DEATH December 18, 1925	Month July	Day 25	Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 18, 1925	9. AGE (In years last birthday) 31	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Year Hours Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Wilbur Wilkins		14. MOTHER'S MAIDEN NAME Edna Langill							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Shock		INTERVAL BETWEEN ONSET AND DEATH 7 days					
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. 4410 X		(b) DUE TO Operative Repair of lital Insufficiency 7 days							
		(c) DUE TO Rheumatic Heart Dis.; lital Insufficiency 18 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1115 X		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Renal Insufficiency							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 5, 1957 to July 25, 1957 , that I last saw the deceased alive on July 25, 1957 , and that death occurred at 8:30 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED July 25, 1957					
ACTUAL SIGNATURE John A. Waldhausen		M.D.		The Clinical Center					
PHYSICIAN'S NAME (Type) John A. Waldhausen, M.D.		National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 7-25-57		22b. DATE THEREOF 7-25-57		22c. NAME OF CEMETERY OR CREMATORIAL Holmes		22d. LOCATION (City, town, or county) Holmes			
23. FUNERAL DIRECTOR'S SIGNATURE J. Stan Lee & Sons		ADDRESS Washington DC		24a. REC'D BY REGISTRAR JUL 29 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson			

BUREAU V. S.

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07601
-14

07634 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE VERMONT	b. COUNTY Chittenden
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLESVILLE	c. LENGTH OF STAY IN 1b 10 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WINOOSKI	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARILEE NURSING HOME	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle HENRY	Last FITZGERALD	4. DATE OF DEATH JULY 6 1957
---	-------------------------	------------------------	---------------------------	--

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 8, 1884	9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0	13. Min. 0
-----------------------	----------------------------------	---	--	--	---	---	-----------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER (RETired)	10b. KIND OF BUSINESS OR INDUSTRY PLUMBING	11. BIRTHPLACE (State or foreign country) WINOOSKI, VERMONT	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	--	---	---

13. FATHER'S NAME JOHN FITZGERALD	14. MOTHER'S MAIDEN NAME CATHERINE COFFEY
---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT MRS. THEO. RHAN, 6920 Willow St. NW DC
--	-------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH 9 days
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Palpitations DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) Heart disease DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Arteriosclerosis, generalized. Intermediate heart disease.	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fracture of skull, laceration of brain, internal hemorrhage.		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Platt'sburgh, New York	20f. (City or town) (County) Platt'sburgh (State) N.Y.

21. I certify that I attended the deceased from January 1952 to July 1957 , that I last saw the deceased alive on July 1957 , and that death occurred at 4:35 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 929 Peckingay Dr., Silver Spring, Md.	DATE SIGNED Aug. 8, 1957
--	------------------------------------

ACTUAL SIGNATURE Frank T. Kunkle	M.D. 929 Peckingay Dr., Silver Spring, Md.
TELEPHONE NAME (Type) 202-243-1234	

22a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT BURIAL	22b. DATE THEREOF JULY 8, 1957	22c. NAME OF CEMETERY OR CREMATORIUM MT. CARMEL CEMETERY	22d. LOCATION (City, town, or county) PLATTSBURGH, NEW YORK
--	--	--	---

23. FUNERAL DIRECTOR'S SIGNATURE Arthur Waller, 254 Carroll St NW, DC	ADDRESS 254 Carroll St NW, DC	24a. REC'D BY REGISTRAR 1057 Lorraine Patten	24b. REGISTRAR'S SIGNATURE 1057 Lorraine Patten
---	---	--	---

BUREAU V. S

JUL 9 1957

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07602

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

FOR STATE
HEALTH DEPT.

DEATH
RECEIVED
4 hours
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
Montgomery		MARYLAND		a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Brookmont		16 yrs.		Brookmont	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RE. DIED F ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4108 Maryland Ave.		4108 Maryland Ave.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year
Orlan			Floro	July 29	19 57
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH	9. AGE (In years at time of death)	
male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Sgt.		U.S. Army		Ohio	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Unknown		Unknown		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO		17. INFORMANT	
(If yes, give war or dates of service)		77-36-476		Rose W. Smith Same as Item 12	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion			
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) _____ (c) _____			
DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN DEATH AND DEATH Found dead on floor of Bed room			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		<i>Frank J. Broschart</i>		DATE SIGNED	
EXAMINER'S NAME (Type)		Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
Burial		8/1/57		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey		Bethesda Maryland		DATE 7-31-57 Bevie M. Thompson	

BUREAU V. 2

JULG 9 1957

REGGIEVIE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07603

07636

CERTIFICATE OF DEATH

Reg. Dist. No. 1216

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Florida b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sarasota 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 901 Windsor Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Dorothy	Middle Evelyn	Last Forbes	4. DATE OF DEATH July 17 1957
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH January 25, 1910	9. AGE (in years from birthday) 47 yrs. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio	
13. FATHER'S NAME Anton Dolezal		14. MOTHER'S MAIDEN NAME Julia Krivanek		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 411 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		DUE TO Cardiac arrest		INTERVAL BETWEEN ONSET AND DEATH 9 hrs	
DUE TO (b) Rheumatic heart disease, c a r d i o s t a s i s				15 yrs	
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 9, 1957, to July 17, 1957, that I last saw the deceased alive on July 17, 1957, and that death occurred at 8:45 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state)		DATE SIGNED 18 July 1957			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) James A. McFarland M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 7/20/57		22c. NAME OF CEMETERY OR CREMATORIUM Parkman Cemetery	
22d. LOCATION (City, town or county) Parkman, Ohio		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		ADDRESS Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 7-19-67	
				24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director,
 it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the record prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07694

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 72 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
3. NAME OF DECEASED (Type or print) Edward		First Leroy	Middle Franks
4. DATE OF DEATH July 3, 1957	Month July	Day 3	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 7, 1920
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY U. S. Park Police	11. BIRTHPLACE (State or foreign country) District of Columbia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		9. AGE (In years last birthday) 36 yrs.	
13. FATHER'S NAME Alpheus Franks		14. MOTHER'S MAIDEN NAME Gertrude Bean	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes		16. SOCIAL SECURITY NO. WW II	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		PULMONARY EDEMA METASTATIC CARCINOMA BRONCHIOGENIC CARCINOMA	
		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 6 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 22, 1957 , to July 3, 1957 , that I last saw the deceased alive on July 3, 1957 , and that death occurred at 8:20 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>I. Bernard Weinstein, M.D.</i>		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/57	22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln
22d. LOCATION (City, town, or county) 3201 Bladensburg Rd. N. E.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		24a. ADDRESS Bethesda, Maryland	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson
VS A15 (4) 15M 9/55		DATE 7-10-57	

RUREAU V. S.

JUL 19 19

REGALIVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exhibited within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07605

07638 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. RAINIER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. PHILOMENA REST HOME		d. STREET ADDRESS 3153 QUEENS CHAPEL ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY MARGARET FREEMAN		4. DATE OF DEATH JULY 6	Month Day Year July 6 1957
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31/71
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM BURGES		14. MOTHER'S MAIDEN NAME ELMIRA MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Violet H. Wilcox, 2921 Tilden St., N.W. Washington, D. C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4x0.0 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Artherosclerotic Heart Disease 20 years (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. MEDICAL CERTIFICATION		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 434.1	
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20e. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20f. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2, 1957, to July 6, 1957, that I last saw the deceased alive on June 2, 1957, and that death occurred at 3:35A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Harry J. Kicherer PHYSICIAN'S NAME (Type) HARRY J. KICHERER		ADDRESS (Street, city or town, state) M.D. 2205 Rockland St. Silver Spring, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/9/57	
22c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) PRINCE GEORGE COUNTY, MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warren S. Humphrey,		ADDRESS ST. SILVER SPRING, MARYLAND	
24a. REC'D BY REGISTRAR DATE 7/10/57		24b. REGISTRAR'S SIGNATURE Janet Miller	

BUREAU V.

UL 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07606

07561

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institutions Residence before admission)				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Takoma Park		c. LENGTH OF STAY IN 1b 5 days		d. STATE Maryland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Washington San + Hosp		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Montgomery		
3. NAME OF (Type or print)		First William	Middle Grover	Last Frenier	4. DATE OF DEATH	Month 7	Day 31	Year 1957
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1-9-88	9. AGE (in years last birthday) 89 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Naval Gun Factory		11. BIRTHPLACE (State or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Frenier				14. MOTHER'S MAIDEN NAME Reddington				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? None		16. SOCIAL SECURITY NO.		17. INFORMANT wife -		Address 9906 Dilston Rd Silver Spring		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 7/26/57				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) Gen Arteriosclerosis (Hypertension)		7				
(c) Aneurysm				7/27/57				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from _____, 1957, to _____, 1957, that I last saw the deceased alive on _____, 1957, and that death occurred at _____ P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. T. Morse</i>								ADDRESS (Street, city or town, state) M.D. 7030 Carroll Ave Takoma Park Md
22a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/3/57		22c. NAME OF CEMETERY OR CREMATORIUM Wash. Nat'l. Mem. Park Cemetery		22d. LOCATION (City, town, or county) Prince George County, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren L. Humphrey</i>		ADDRESS Silver Spring, Maryland		24a. REC'D. BY REGISTRAR DATE 8/3/57		24b. REGISTRAR'S SIGNATURE <i>Wilson Dill</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Loge 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Loge 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

UG 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07607

(7639)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b Suburban Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 5932 Anniston Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) AGNES		First A.	Middle GARDNER	4. DATE OF DEATH July 17,	Month 1957	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1866	9. AGE (In years lost birthday) 90 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? Naturalized U.S.A.		
13. FATHER'S NAME Samuel Lockyer Baker		14. MOTHER'S Maiden NAME Elizabeth Jarvis		15. WAS DECEASED EVER IN U.S. ARMED FORCES (For no or unknown) No		16. SOCIAL SECURITY NO. FELL		17. INFORMANT Daughter Evelyn Gardner
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>HEART</i>		HIP FRACTURE R.		19. INTERVAL BETWEEN ONSET AND DEATH 6 WKS.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROSIS - GENERAL + CEREBRAL.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) FELL AT HOME		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) BETHESDA, MONTGOMERY, MD (County) (State)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. 1957 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e.				
21. I certify that I attended the deceased from _____, 1957, to _____, 1957, that I last saw the deceased alive on _____, 1957, and that death occurred at _____, 1957, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Seymour Greenbaum</i>		M.D. 9300 EWING DR. BETHESDA, MD.		ADDRESS (Street, city or town, state) SEYMOUR GREENBAUM, M.D.		DATE SIGNED 7/19/57		
22a. BURIAL, CREMATION, <input type="checkbox"/> DATE THEREOF Burial Trans 7/19/57		22c. NAME OF CEMETERY OR CREMATORIUM Flushing Cemetery		22d. LOCATION (City, town, or county) Flushing, New York (State)				
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 7-19-57		24b. REGISTRAR'S SIGNATURE <i>Bennie M. Thompson</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

1957

RECEIVED

1
FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08653 2/16
Reg. Dist. No.

£7640

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN lb 7 years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3308 Cummings Lane

2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission)
a. STATE Maryland b. COUNTY Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase

d. STREET ADDRESS 3308 Cummings Lane

e. IS REL'D ON A FARM
YES NO

3. NAME OF DECEASED (Type or print) First Middle Last DATE OF DEATH Month Day Year
Nellie R. GARVER July 21 19 57

4. SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years from birthday) 10. IF UNDER 1 YEAR
Female White WIDOWED DIVORCED Sept. 19, 1875 81 yrs 10 months 2 days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?
Hagerstown, Maryland USA

13. FATHER'S NAME Thomas Benton Grimm 14. MOTHER'S MAIDEN NAME Adelaide V. Spangler Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT
[Yes, no, or unknown] [If yes, give war or dates of service] None Mrs. Helen R. Gleason-Same Item #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4. 2/1 DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause (c) DUE TO
cause lost. (c)

CORONARY THROMBOSIS 5 min.

19. WAS AUTOPSY PERFORMED?
YES NO

20. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

Hour a. m. p. m. While at work Not while at work

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE John G. Ball, M. D. DATE SIGNED 7/21/57

EXAMINER'S NAME (Type) John G. Ball, M. D.

22a. BURIAL CREMATION REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM 22d. LOCATION (City, town, or county) (State)

Burial 7/24/1957 Rose Hill Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md. DATE 7/20/57 Besse Thompson

תְּפִיכָּה

טַבָּה

תְּמִימָה

1

**FOR STATE
HEALTH DEPT.**

TO FUNERAL DIRECTOR: Please sign and file this certificate. It should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be referred to for your files.

TO ITS DESIGNATED AGENT: Please sign and file this certificate, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08655

Reg. Dist. No. 223

07562

1. PLACE OF DEATH o COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Takoma Park		o STATE Maryland b COUNTY Prince George's	
c. LENGTH OF STAY IN lb		2 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Oakhaven Nursing Home 517 Albany Ave.		d. STREET ADDRESS	
e. NAME OF DECEASED (Type or print)		First	Middle	Post	4. DATE OF DEATH
f. SEX		6 COLOR OR RACE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	Month	July 28
female		white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Day	Doy 19 57
9. AGE (In years to nearest month)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country)		housewife U.S. GOVT.		11. INFORMANT	
12. CITIZEN OF WHAT COUNTRY?		Beau of Engr & Print New York		Clarkson Gemmill, 6625 Piney Branch Road, Takoma Park.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address	
Levi Stevens		Margaret Helen Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT	
		None		Clarkson Gemmill, 6625 Piney Branch Road, Takoma Park.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Carcinoma of both breasts with generalized metastasis.			
170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO			
(b)					
(c)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 years			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, 120 ^f (City or town) factory, street, office bldg., etc.)	
19				(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		<i>Frank J. Broschart</i>			
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF July 31, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	
22d. LOCATION (City, town, or county) Suitland, Prince Geo. Co., Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Alexander Wallace</i>		ADDRESS 254 Carroll St. R: F:		24a. REC'D BY REGISTRAR DATE 7/31/57	
				24b. REGISTRAR'S SIGNATURE <i>J. Wilson Dodd</i>	

RECEAU V. S

AUG 1 1961

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07589

CERTIFICATE OF DEATH

07608

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D C		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 4000 Cathedral Avenue NW		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waverley Saniterium						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Henrietta		First Henrietta	Middle H.	Last Glaser	4. DATE OF DEATH July 13 1957	Month July	Day 13	Year 1957
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec 7, 1866	9. AGE (in years last birthday) yrs. 90	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0	13. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) D C		12. CITIZEN OF WHAT COUNTRY? 4000 Cathedral Ave NW Washington, D C		
13. FATHER'S NAME Joseph Herzog		14. MOTHER'S MAIDEN NAME Rachel Hammarschlag						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Irvin Schloss		Address 4000 Cathedral Ave NW Washington, D C		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Arterio-venous Heart Disease</i>				INTERVAL BETWEEN ONSET AND DEATH 3 years		
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b)		<i>Arteriosclerosis - Generalized</i>				16 years		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Parkinson's Disease</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) GARRETT PARK, MARYLAND	(County) GARRETT PARK, MARYLAND	(State) MARYLAND	
21. I certify that I attended the deceased from March , 19 56 , to July 13, 1957 , that I last saw the deceased alive on July 12, 1957 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) GARRETT PARK, MARYLAND DATE SIGNED JULY 13, 1957								
ACTUAL SIGNATURE <i>Joseph H. Watson</i>	PHYSICIAN'S NAME (Type) JOSEPH H. WATSON, MD		GARRETT PARK, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/15/57	22c. NAME OF CEMETERY OR CREMATORIAL Washington Hebrew Cong.		22d. LOCATION (City, town, or county) Washington		(State) D C		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph H. Watson, MD</i>		1756 ADDRESS Pennsylvania Ave NW, Washington, DC		24a. REC'D BY REGISTRAR 7/17/57	24b. REGISTRAR'S SIGNATURE <i>Joseph H. Watson, MD</i>			

TO ATTEND OR ATTENDED PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07563

CERTIFICATE OF DEATH

07609

Reg. Dist. No. 3

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brookside Park</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>1724 - 11th & 3rd</i>		d. STREET ADDRESS <i>1658 E St. - Takoma Park</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>in Hospital</i>				d. STREET ADDRESS <i>1658 E St. - Takoma Park</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Virginia Katherine Haney</i>		First	Middle	Last	4. DATE OF DEATH <i>July 19 1957</i>	Month	Day	Year	
5. SEX <i>F</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>1-37-9</i>	8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <i>49 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Lee S. & Virginia K. Haney</i>		14. MOTHER'S MAIDEN NAME <i>Eva Haney</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? [Yes, no or unknown] <i>No</i>		16. SOCIAL SECURITY NO. <i>[Redacted]</i>		17. INFORMANT <i>John G.</i>		Address <i>[Redacted]</i>			
18. CAUSE OF DEATH [Enter only one cause per line] (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Hypertensive heart disease</i> DUE TO (c) <i>Essential hypertension</i>									
INTERVAL BETWEEN ONSET AND DEATH <i>1 to 7 hrs</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral hemorrhage</i>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D.</i>		20f. (City or town) <i>Takoma Park</i>		(County) <i>Takoma Park</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>July 23, 1957</i> , to <i>July 25, 1957</i> , that I last saw the deceased alive on <i>July 25, 1957</i> , and that death occurred at <i>7600 Carroll Ave</i> , M.D., from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <i>7600 Carroll Ave</i>									
DATE SIGNED <i>July 25, 1957</i>									
ACTUAL SIGNATURE <i>Raymond O. West M.D.</i>		PHYSICIAN'S NAME (Type) <i>Raymond O. West</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>		22b. DATE THEREOF <i>7/29/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Ft. Lincoln Crematory</i>		22d. LOCATION (City, town, or county) <i>Prince Georges Co., Md.</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Jones Company</i>		ADDRESS <i>2901-14th & 3rd</i>		24a. REC'D BY REGISTRAR DATE <i>7/30/57</i>		24b. REGISTRAR'S SIGNATURE <i>J. Wilson Daddy</i>			

1. **HOSPITAL** OR **ATTENDANT PHYSICIAN:** This law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3. may be retained by the hospital or attending physician.

RECEIVED
BUREAU V. S.

JUL 20 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07610

07641

CERTIFICATE OF DEATH

Reg. Dist. No.

215

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 2 hr. 12 min.		b. COUNTY District of Columbia	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
3. NAME OF DECEASED (Type or print)		First Baby	Middle Boy	Last GREEN	4. DATE OF DEATH July 7 1957
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 6 July 1957	9. AGE (In years last birthday) yrs IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Bobby GREEN		14. MOTHER'S MAIDEN NAME Mary Francis BELL		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Bobby GREEN (Same s #2)	
Address 44					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754-14 DUE TO Congenital Heart Disease				INTERVAL BETWEEN ONSET AND DEATH 2 hrs 12 min	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (c)					
DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Esophageal Atresia & Double Fistula				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 6, 1957, to July 7, 1957, that I last saw the deceased alive on July 7, 1957, and that death occurred at 1:22 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>J.C. Parke</i>				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. 7-9-57 DATE SIGNED	
PHYSICIAN'S NAME (Type) J.C. PARKE, JR. LT MC USN		U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-12-57		22c. NAME OF CEMETERY OR CREMATORIAL Private Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 7-9-57	
				24b. REGISTRAR'S SIGNATURE <i>Barry L. Farrell</i>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.
REFEIVEO

JUL 10 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07642

CERTIFICATE OF DEATH

07615214
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b RURAL and give nearest town		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Md.		b. COUNTY Montgomery	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 210 Southampton Drive				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 210 Southampton Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edith		First	Middle Clokey	Last Green	4. DATE OF DEATH July 29	Month July	Day 29	Year 1957	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/1/1895	9. AGE (In years from birthday) 61 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Clokey				14. MOTHER'S MAIDEN NAME Ella Hunter					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) 932X		16. SOCIAL SECURITY NO.		17. INFORMANT Betty G. Green- 3304 Collier Road Adelphi, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost Maligant Hypertension						INTERVAL BETWEEN ONSET AND DEATH			
(b) Cerebral Accident 9 years ago									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 445X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 2021 Que Street, N.W.		(County)	(State)
21. I certify that I attended the deceased from July 24 , 1957, to July 24 , 1957, that I last saw the deceased alive on July 24 , 1957, and that death occurred at 430 M. from the causes and on the date stated above						ADDRESS (Street, city or town, state) 2021 Que Street, N.W.		DATE SIGNED	
ACTUAL SIGNATURE Hugo Einstein									
PHYSICIAN'S NAME (Type) Hugo Einstein						2021 Que Street, N.W.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8/1/1957		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Prince Georges County, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901 11th St., N.W. Washington 9, D.C.		24a. REG'D BY REG'D DATE AUG 1 1957		24b. REGISTRAR'S SIGNATURE Frances Potts			

1
TENURE PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THEATRE

JUG 1 1957

REGGIE FEE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07612
214

07643

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Washington, D.C.</i> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>1 yr. 5 mos.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cedarcroft Sanitarium & Hospital</i>		d. STREET ADDRESS <i>108 E Street, N.W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>ELIZA</i>	Middle <i>S.</i>	Last <i>GREL.</i>	4. DATE OF DEATH <i>July 30 1957</i>	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>December 30, 1865</i>	9. AGE (in years last birthday) <i>91 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>	
13. FATHER'S NAME <i>David Green</i>		14. MOTHER'S MAIDEN NAME <i>Mary Pilson</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Edward McGovern, 108 E st., N.E., Wash. D.C.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the Bladder</i> (b) <i>Juvenile; brain disease with psychosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (c) <i>Chronic Cardio-Vascular Disease</i> DUE TO (c) <i>Myocardial infarction associated with hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH Duration of (a) or (b): Indefinite.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Washington, D.C.</i>	(County) <i>D.C.</i> (State) <i>MD.</i>
21. I certify that I attended the deceased from <i>2-1-56</i> , 19 <i>56</i> , to <i>7-30-57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>7-30</i> , 19 <i>57</i> , and that death occurred at <i>3:00 PM</i> , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <i>Alvin J. Kistler, M.D., Cedarcroft Sanitarium, Silver Spring, Md.</i>					
DATE SIGNED <i>Alvin J. Kistler, M.D., Cedarcroft Sanitarium, Silver Spring, Md.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/1/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Oak Hill Cemetery</i>	22d. LOCATION (City, town, or county) <i>Washington, D.C.</i> (State) <i>MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>X</i>		ADDRESS <i>Frances P. Pumphy</i>	24a. REC'D BY REGISTRAR <i>VS A15 14</i>	24b. REGISTRAR'S SIGNATURE <i>Frances P. Pumphy</i>	
			DATE <i>8/1/57</i>		
VS A15 14 15M 9/55					

BUREAU Y.

MUG 5 1957

KODAK SAFETY FILM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07614
7/23

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D. C.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 3909 Benton St. N. W.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oakhaven Rest Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Mattie	Middle P.	Last Gregory	4 DATE OF DEATH July 17,	Month July	Day 17	Year 1957
S SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 22, 1872	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 84	IF UNDER 24 HRS. Days hrs.	Hours min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Walkersville Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Jacob Perry				14. MOTHER'S MAIDEN NAME Martha Gesey				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		Address Grace Smith (neice) 3909 Benton St. N.		
18. CAUSE OF DEATH [Enter only one cause per line 18 (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>18-year-old Paralytic</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Thrombosis</i> DUE TO (c) <i>Second Arterial Disease</i>								
INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 450.0								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 206-6		20f. (City or town) (County) (State) Frederick, Md.		
21. I certify that I attended the deceased from July 17, 1957 to July 17, 1957 that I last saw the deceased alive on July 17, 1957 , and that death occurred at 206-6 , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 306-6, Frederick, Md.								
DATE SIGNED 7/23/57								
MEDICAL CERTIFICATION RELEASER SIGNATURE J. Stuart Lloyd, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 19, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cem.		22d. LOCATION (City, town, or county) (State) Frederick, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home 4812 Ga. Ave. N.W.				ADDRESS Washington D.C.		24a REC'D BY REGISTRAR DATE 22.1957		
						24b REGISTRAR'S SIGNATURE J. Wilson Davis		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 2 & 3 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

JUL 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07615

07644

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) o. STATE	Maryland	b. COUNTY	Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Length of stay in bed	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Gaithersburg RFD #3			
Bethesda		Gaithersburg				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Suburban						

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Clyde			Griffith	7	15	1957	

5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS
Male	white	WIDOWED <input checked="" type="checkbox"/>	MAR-17-1880	97 yrs	Months	Days
		DIVORCED <input type="checkbox"/>			Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	FARMER	Darnestan, Md.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Julian Griffith	Mary Virginia Harper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
	27-36-8423	Miss Alice Griffith (Daughter)	Ave.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior Myocardial Infarction	4 days
DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
(b) Coronary artery thrombosis	4 days
DUE TO	
(c) Arteriosclerotic cardiovascular disease	years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Arthritis 725X	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
19					

21. I certify that I attended the deceased from July 17, 1957, to July 18, 1957, that I last saw the deceased alive on July 17, 1957, and that death occurred at 7:45 AM, from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED
William C. Miller	7-Brook Ave., Gaithersburg, Md.	

ACTUAL SIGNATURE	PHYSICIAN'S NAME (Type)
William C. Miller	William C. Miller

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county)	(State)
Burial	July 20/57	Darnestown Cemetery	Darnestown	Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Ernest G. Hartman, Gaithersburg		DATE 7-24-57	Bessie M. Thompson

RECEIVED

JUL 26 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07616

07590

CERTIFICATE OF DEATH

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN lb 2 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 602 Dean Dr.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First Abigail	Middle Elizabeth	Last Grignon	4. DATE OF DEATH July 13 1957	Month	Day	Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6/16/80	9. AGE (in years last birthday) 77 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY —			11. BIRTHPLACE (State or foreign country) N. Hampshire			
12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Thomas Griffin			14. MOTHER'S MAIDEN NAME BRIDGET HARTY						
15. WAS EVER SERVED IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.			17. INFORMANT Son - Henry Grignon - Rockville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic Cardiovascular Disease 15 yr. DUE TO (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 8 hr.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 221V			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) None			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bellows Falls		(County) Vt.	(State) Vt.
21. I certify that I attended the deceased from May 13 1957 to July 13 1957 , that I last saw the deceased alive on July 12 1957 , and that death occurred at 12 AM , from the causes and on the date stated above.									
ACTUAL SIGNATURE Stephen C Cromwell M.D. ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 7/13/57									
PHYSICIAN'S NAME (Type) Stephen C. Cromwell, M.D.		22d. LOCATION (City, town, or county) Bellows Falls Vt.							
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF July 13 1957		22g. NAME OF CEMETERY OR CREMATORIAL W.W. Taltorrell 3619-14th & NW		22h. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Taltorrell		ADDRESS 1057		24a. REC'D BY REGISTRAR DATE 1057		24b. REGISTRAR'S SIGNATURE Lawell Fragley			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial permit. Then, please remove carbon papers. Pages 2 should be filed with the register or prior to burial, cremation, removal, and in any event within 72 hours after death.

BUREAU V. S

77 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07617

07645

CERTIFICATE OF DEATH

Reg. Dist. No. 616

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE	
MONTGOMERY MARYLAND		MONTGOMERY MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
BETHESDA	1 1/2 hours	ROCKVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
SUBURBAN HOSP.	R.R. #12		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	BILLIE	WAYNE	CRIMES
4. DATE OF DEATH	Month	Day	Year
JULY 9			1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	JULY 15, 1957
9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
— yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	MONTGOMERY COUNTY	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
ERNEST WILSON CRIMES SR.	SARAH CATHERINE SLICK		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
—	—	ERNEST WILSON CRIMES SR. - (Father)	—
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	INTERVAL BETWEEN ONSET AND DEATH 120 hrs.		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	PNEUMONIA - BILATERAL		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/9/57 to 7/19/57, that I last saw the deceased alive on 7/9/57, and that death occurred at 8:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Jea W. Pedersen PHYSICIAN'S NAME (Type)	ADDRESS (Street, city or town, state) DATE SIGNED 4700 - BRADLEY BLVD. EAST BALTIMORE, MD. 21212		
22a. BURIAL, CREMATION, REMOVAL <input type="checkbox"/> July 12, 1957	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
		Mt. Lebanon	Etchison, Md.
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Roy W Barber Laytonsville, Md.		DATE 7-13-57	Barber, Roy W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

JUL 16 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07618

07646 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Florida		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Petersburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. STREET ADDRESS 3644 Burlington Ave., North		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Paul	Middle Girard	Last GROSSHANS	4. DATE OF DEATH July	Month July	Day 11	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12 Feb. 1933	9. AGE (in years lost birthday) 24 yrs.	10. IF UNDER 1 YEAR Months 24	11. IF UNDER 24 HRS Days hrs. min.	12. CITIZEN OF WHAT COUNTRY? U.S.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		11. BIRTHPLACE (State or foreign country) New York			
13. FATHER'S NAME Paul Grosshans							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Currently Unknown		17. INFORMANT (Wife) Mrs. Dorothy L. GROSSHANS (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.1		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Leukemia, myelogenous acut		3 weeks		(c)			
DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 571X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) 20e. (City or town) (County) (State)	
20f. (City or town) U.S. Naval Hospital, Bethesda, Md.		20g. DATE OF INJURY 7-12-57		20h. DATE OF DEATH 7-12-57		20i. (City or town) Arlington, Virginia	
21. I certify that I attended the deceased from 9 July , 1957, to 11 July , 1957, that I last saw the deceased alive on 11 July , 1957, and that death occurred at 4:10 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 7-12-57							
ACTUAL SIGNATURE Gerald I. Shugoll M.D. U.S. Naval Hospital, Bethesda, Md. 7-12-57							
PHYSICIAN'S NAME (Type) Gerald I. Shugoll, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-16-57		22c. NAME OF CEMETERY OR CREMATORIUM Washington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 7-12-57		24b. REGISTRAR'S SIGNATURE Barry E. Parnell	

BUREAU V.

UL 15 1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

67619

FOR STATE
HEALTH DEPT.17-
17-
17-

8:3219 8-29-1957

07647

Reg. Dist. No. 216

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This cert'f'cote should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M-3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY MONTGOMERY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BETHESDA

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
5212 Baltimore Avenue

3. NAME OF
DECEASED
(Type or print) IRENE MacDONALD

First

Middle

Last

DATE
OF
DEATHMonth
JulyDay
20Year
1957

5. SEX FEMALE COLOR OR RACE WHITE MARRIED NEVER MARRIED 8. DATE OF BIRTH 1898

WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired

10b. KIND OF BUSINESS OR INDUSTRY US Government

11 BIRTHPLACE (State or foreign country)
Philadelphia, Pa.

12. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.

13. FATHER'S NAME

Donald MacDonald

14. MOTHER'S MAIDEN NAME

Unk Penn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Tel. no. or unknown)
no

16. SOCIAL SECURITY NO.

17. INFORMANT

Vincent M. Hancock, 52 12 Baltimore, AVE Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Generalized Peritonitis

INTERVAL BETWEEN
ONSET AND DEATH
4 days

DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)
DUE TO
(c)

Gangrenous Appendicitis

4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

John G. Ball

M.D. CHIEF MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S
NAME (Type)

JOHN G. BALL, MD

ASSISTANT MEDICAL EXAMINER

22a. BURIAL, CREMATION, REMOVAL (Specify)
cremation 7-23, 1957

22b. NAME OF CEMETERY OR CREMATORIUM

Cedar Hill Crematory

22c. LOCATION (City, town, or county)

Suitland Md

57.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Bethany Sos 1756 Pa. Ave. NW D.C. ADDRESS

24a. REC'D BY REGISTRAR

DATE 7-27-57

24b. REGISTRAR'S SIGNATURE

Bessie M. Sampson

UREAU V. S.

JUL 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07620
223

C7565 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MD b. COUNTY Flower Ave							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN lb 6 days							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM & HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK, Md							
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Timothy Joseph Hanley		First T	Middle I	Last Hanley	4. DATE OF DEATH July 18 1957	Month July	Day 18	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/3/77	9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 7	Days 0	Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK - R.R.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Hanley		14. MOTHER'S MAIDEN NAME MARGARET Kelley				Address 7222 Flower Ave			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 014-07-4309		17. INFORMANT Daughter Eileen Hanley		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
						INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) Infected Bromodorsia, skin (2) Secondary Anemia		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. I certify that I attended the deceased from July 18 , 1957, to July 18 , 1957, that I last saw the deceased alive on July 18 , 1957, and that death occurred at 5:55 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Dean H. Harding PHYSICIAN'S NAME (Type) DEAN H. HARDING			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 113 Carroll St. NW, Washington, D.C.		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 18 , 1957, to July 18 , 1957, that I last saw the deceased alive on July 18 , 1957, and that death occurred at 5:55 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Dean H. Harding PHYSICIAN'S NAME (Type) DEAN H. HARDING		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 20, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll St. NW - H.C.		24. ADDRESS ADDRESS		24a. REC'D BY REGISTRAR DATE 7/10/57		24b. REGISTRAR'S SIGNATURE J. Arthur Walters			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU X

JUL 22 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07621

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6m days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X-1 Wheaton	
3. NAME OF DECEASED (Type or print) Andrew Christian Hansen		First A	Middle ndrew
		Last Hansen	4. DATE OF DEATH July 17 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1918-Oct. 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Bldg. Indus.	11. BIRTHPLACE (State or foreign country) Illinois - Cook
13. FATHER'S NAME George Clarence Hansen		14. MOTHER'S MAIDEN NAME Wilhemina Hatzel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 351-03-7589	17. INFORMANT Mrs. Geraldine Hansen (Wife)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO		INTERVAL BETWEEN ONSET AND DEATH Intracerebral Hemorrhage	
{ (b) DUE TO Ruptured Congenital Aneurysm of Rt. Middle Cerebral Artery (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 17, 1957 to July 17, 1957 , that I last saw the deceased alive on July 17, 1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE John T. Lord		ADDRESS (Street, city or town, state) DATE SIGNED July 17, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 22, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cem.
22d. LOCATION (City, town, or county) Fort Myer, Va.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warren G. Humphrey		24a. ADDRESS Silver Spring, Md.	24b. REC'D BY REGISTRAR DATE 7-28-57
		REGISTRAR'S SIGNATURE Bessie M. Thompson	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A-1

JUL 25 1957

REGEIVEGO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07622

215

07643

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Florida		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 53 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miami				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 18005 N.W. 8th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Robert	Middle Bernard	Last HOLDEN	4. DATE OF DEATH	Month July	Day 13	Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 18 Jan. 1921	9. AGE (in years last birthday) 36	IF UNDER 1 YEAR Months 36	IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Felix F. HOLDEN			14. MOTHER'S MAIDEN NAME Grace Ward					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) If yes, give war or dates of service yes 2-14-58 to 4-1-52			16. SOCIAL SECURITY NO Unknown			17. INFORMANT (Wife) Margarita HOLDEN (Same As #2)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) mitral valve stenosis 410 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Rheumatic Heart Disease (c)						INTERVAL BETWEEN ONSET AND DEATH 3 years Indefinite		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) metastatic embryonal (Testicular) carcinoma						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) from the causes and on the date stated above.						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED Not while of work <input type="checkbox"/> While of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 21 May 1957 , to 13 July 1957 , that I last saw the deceased alive on 13 July 1957 , and that death occurred at 11:23A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 7-15-57								
ACTUAL SIGNATURE <i>R. J. Mc Carthy</i>	M.D. U.S. Naval Hospital, Bethesda, Md. 7-15-57							
PHYSICIAN'S NAME (Type) R. J. MC CARTHY, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-17-57		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Pumphrey</i>		ADDRESS 11557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 7-15-57		24b. REGISTRAR'S SIGNATURE <i>Barry E. Farrelly</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; **Page 2** should be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, **page 3** should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages **2** and **3** should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

JUL 10 1977

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17628
215 23

7650

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 58 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		d. STREET ADDRESS 37 South French Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Charles	Middle Franklin	Last HUDSON	4. DATE OF DEATH July 3, 1887	Month July	Day 3	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1887	9. AGE (In years from last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Alfred Brown HUDSON				14. MOTHER'S MAIDEN NAME Rose WEBER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI & WWII		17. INFORMANT Unknown		Address (Son) Charles F. HUDSON, Jr. (Same as #2)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis						INTERVAL BETWEEN ONSET AND DEATH Indefinite		
DUE TO 4/20.1								
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. Generalized Atherosclerosis, Severe		(b)				indefinite		
DUE TO Generalized Atherosclerosis, Severe		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 6, 1957 , to July 3, 1957 , that I last saw the deceased alive on July 3, 1957 , and that death occurred at 10:55 PM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>R.J. Mc Carthy</i>		ADDRESS (Street, city or town, state) M.D. U.S. Naval Hospital, Bethesda, Md. 7-4-57.						DATE SIGNED
PHYSICIAN'S NAME (Type) R.J. MC CARTHY, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 7-9-57		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery		22d. LOCATION (City, town, or county) Arlington		(State) Virginia
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphrey</i>		ADDRESS R.A. Pumphrey, 7757 Wisc. Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR Barry & Garey		24b. REGISTRAR'S SIGNATURE <i>Barry & Garey</i>		
						DATE 7-4-57		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGELIVE
BUREAU Y. S

JUL 15 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07624

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland/Florida b. COUNTY		Escambia	
Montgomery				Maryland		Florida			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River		Pensacola			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS U.S. Naval Air Station		e. DATE OF DEATH 27 July 1957		f. IS RESIDENCE ON A FARM? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Nick	Middle Charles	Last ICE, Jr.	Month July	Day 29	Year 1957		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 27 July 1957	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months 2 Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.			
13. FATHER'S NAME Nick Charles ICE, Sr.					14. MOTHER'S MAIDEN NAME Edna Rose DAVIS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Nick Charles ICE, Sr. (Same As #2)		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 774X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Pulmonary Hyaline Membrane Disease					INTERVAL BETWEEN ONSET AND DEATH				
 DUE TO Prematurity					2 days				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) U.S. Naval Hospital, Bethesda, Md.		(County)	(State)
21. I certify that I attended the deceased from 28 July 1957, to 29 July 1957, that I last saw the deceased alive on 29 July 1957, and that death occurred at 2:25 P. M., from the causes and on the date stated above					ADDRESS (Street, city or town, state)				
ACTUAL SIGNATURE Russell Miller, Jr. M.D.					DATE SIGNED 7-30-57				
PHYSICIAN'S NAME (Type) Russell Miller, Jr. LT, MC, USN					U.S. Naval Hospital, Bethesda, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 13 August 1957		22c. NAME OF CEMETERY OR CREMATORIY Brentwood Cemetery		22d. LOCATION (City, town, or county) Pensacola, Florida		(State)	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CORPORATE DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

F7652

CERTIFICATE OF DEATH

Reg. Dist. No.

217

87625

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheyney</i>		c. LENGTH OF STAY IN 1b <i>1 mo 19 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chillum</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Chronic Hosp -</i>		d. STREET ADDRESS <i>5802 Riggs Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Milford</i>	Middle <i>O.</i>	Last <i>Jarus</i>	4. DATE OF DEATH	Month <i>July</i>	Day <i>1</i>	Year <i>1957</i>
5. SEX <i>M-</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 28 1887</i>	9. AGE (In years last birthday) <i>73 yrs</i>	10. UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Realestate Salesman</i>		11. BIRTHPLACE (State or foreign country) <i>Michigan</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Milford Meade Jarus</i>		14. MOTHER'S MAIDEN NAME <i>Rose Emily Carter</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Milford O. Jarus</i>		Address <i>5802 Riggs Rd. Chillum Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL THROMBOSIS -</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>GEN. ARTERIOSCLEROSIS +</i> DUE TO (c) <i>SENILITY</i>						INTERVAL BETWEEN ONSET AND DEATH <i>8 HRS</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>450.0</i>		21. I certify that I attended the deceased from <i>July 12, 1957</i> , to <i>July 1, 1957</i> , that I last saw the deceased alive on <i>July 1, 1957</i> , and that death occurred at <i>11:20 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>John B. Ziegler</i>		ADDRESS (Street, city or town, state) <i>Odney Md</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Fairfax Co. Va</i>		20f. (City or town) <i>Fairfax Co. Va</i>	(County) <i>Fairfax Co. Va</i>
21. I certify that I attended the deceased from <i>July 12, 1957</i> , to <i>July 1, 1957</i> , that I last saw the deceased alive on <i>July 1, 1957</i> , and that death occurred at <i>11:20 PM</i> , from the causes and on the date stated above. PHYSICIAN'S NAME (Type) <i>Dr. John B. Ziegler</i>		M.D.				DATE SIGNED <i>2 July 57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-5-57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Fairfax Church</i>		22d. LOCATION (City, town, or county) <i>Fairfax Co. Va</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.W. Lee & Son's Co.</i>		ADDRESS <i>300 4th N.E. Wash. D.C.</i>		24. REC'D BY REGISTRAR DATE <i>15 1957</i>		25. REGISTRAR'S SIGNATURE <i>Gertrude Lavelle</i>	

BUREAU V. S

JUL 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07653

CERTIFICATE OF DEATH

07626
314

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Nursing Home 14326 Colesville Rd., Mrs. Green's				d. STREET ADDRESS 1434 Geranium St. N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Katherine		First V.	Middle Johnston	4. DATE OF DEATH July 14,	Month Day Year 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/8/1867	9. AGE (In years last birthday) 90	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Samuel M. Dalzell		14. MOTHER'S MAIDEN NAME Louise V. Wilson		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Alvin Wilson Luckett Address 1434 Geranium St. NW	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH 14 days					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) Cerebral Arteriosclerosis 107 years (c) Generalized arteriosclerosis 207 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 450.0					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. s. p. m.	Month July	Day 14	Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January , 1957, to July 14 , 1957, that I last saw the deceased alive on July 6, 1957 , and that death occurred at 7:42 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE R. Stephen Hulbert M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) R. Stephen Hulbert, M.D. Washington, D.C. DATE SIGNED July 14, 1957					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 7/16/1957	22c. NAME OF CEMETERY OR CREMATORIUM Congressional Cemetery	22d. LOCATION (City, town, or county) Washington, D.C.		
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR DATE 16 1957	24b. REGISTRAR'S SIGNATURE Frances Polley		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 page 3, and be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07627

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 day		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE North Carolina		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warsaw	
						b. COUNTY Duplin Co.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS R.F.D. #2		d. STREET ADDRESS 714		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Roland		First Jack		Last Johnston		4. DATE OF DEATH July 23, 1957	Month July	Day 23	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH February 3, 1904	9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS. Days 20	Hours 5	Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Will J. Johnston				14. MOTHER'S MAIDEN NAME Annie Melville					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Metastatic malignant melanoma INTERVAL BETWEEN ONSET AND DEATH 5 yrs.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO (b) Lobular pneumonia DUE TO (c)								5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)					
21. I certify that I attended the deceased from July 22, 1957 , to July 23, 1957 , that I last saw the deceased alive on July 23, 1957 , and that death occurred at 5:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland								DATE SIGNED 7/23/57	
ACTUAL SIGNATURE Edward W. Moore		PHYSICIAN'S NAME (Type) Edward W. Moore		22d. LOCATION (City, town, or county) Warsaw, North Carolina (State)					
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/25/57		22c. NAME OF CEMETERY OR CREMATORIUM Pine Crest Cemetery		22d. LOCATION (City, town, or county) Warsaw, North Carolina (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24c. REC'D BY REGISTRAR DATE 7-23-57		24b. REGISTRAR'S SIGNATURE Benito M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 25 1957

REVEO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07628

07655

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN 1b

21 Years

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

8401 Dixon Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

8401 Dixon Avenue

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

Patrick

First

Middle

Last

4. DATE
OF
DEATHJuly
9
1957

Month

Day
Year

5. SEX

Male

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Feb. 1 1872

9. AGE (In years
lost birthday)
85 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Custodian - Guardian Bldg. & Loan

10b. KIND OF BUSINESS OR INDUSTRY

Ireland

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Joyce

14. MOTHER'S MAIDEN NAME

Anna Kessiry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

578-05-72-7A

17. INFORMANT

Lawrence Joyce

Address 1745 Overlook Drive
Silver Spring, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cerebral thrombosis

INTERVAL BETWEEN
ONSET AND DEATH
48 hrs

4/2/1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Arterio-sclerotic cardio-vascular disease 5 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from May 15, 1953, to July 9, 1957, that I last saw the deceased alive on July 8, 1957, and that death occurred at 11:30 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Raymond Bradshaw, M.D. 345 University Boulevard, West 7/9/57

PHYSICIAN'S
NAME (Type)

Raymond Bradshaw

silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL

7/10/57

22b. DATE THEREOF

Washington Nat'l. Cemetery

22c. NAME OF CEMETERY OR CREMATORIUM

Prince George County, Md.

(State)

(City, town, or county)

23. FUNERAL DIRECTOR'S SIGNATURE

Warren L. Humphrey

ADDRESS
SILVER SPRING, MD.RECD BY REGISTRAR
DATE 7/12/57REGISTRAR'S SIGNATURE
James Jettler

BUREAU Y. S.

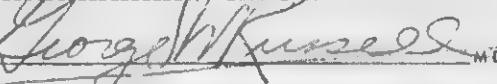
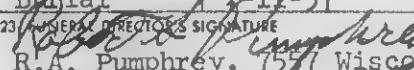
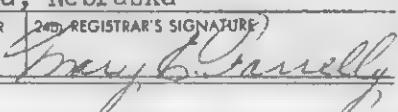
110-1-100

KODAK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
(7656) CERTIFICATE OF DEATH

07629.

Reg. Dist. No. 215

PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Virginia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 54 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midway Island				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS #6 Marvel Manor		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Mary	Middle Kathryn	Last KAHLER	4. DATE OF DEATH July 5 1957	Month July	Day 5	Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12 April 1916	9. AGE (In years lost birthday) 41 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Housewife)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME James S. Kimsey			14. MOTHER'S MAIDEN NAME Olive Fisher					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT (Husband) Jack W. KAHLER (Same As #2)		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 170X DUE TO Glycombocytopenic Purpura INTERVAL BETWEEN ONSET AND DEATH 3 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Skeletal Metastases 15 months (c) Carcinoma of Breast 22 months								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 12 May 1957 to 5 July 1957 , that I last saw the deceased alive on 5 July 1957 , and that death occurred at 12:10 PM , from the causes and on the date stated above. ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type) George W. Russell, CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md. 7-5-57 ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 7-5-57								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-5-57		22c. NAME OF CEMETERY OR CREMATORIUM Private Cemetery		22d. LOCATION (City, town, or county) Stella, Nebraska (State)		
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS R.A. Pumphrey, 1571 Wisconsin Ave, Bethesda, Md.		24a. REC'D BY REGISTRAR 7-5-57		24b. REGISTRAR'S SIGNATURE 		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CHINEAU V.

1957

DESATIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07630
223

07566

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tiboma Park</i>		c. LENGTH OF STAY IN TB <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		d. STREET ADDRESS <i>2207 Rockland St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Robert</i>		First	Middle	Last	4. DATE OF DEATH <i>Kaufmann</i>	Month	Day	Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-6-13</i>		9. AGE (In years last birthday) <i>44 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Buyer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Jewelry</i>		11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Siegfried Kaufmann</i>		14. MOTHER'S MAIDEN NAME <i>Frieda Lorig</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>No</i>		16. SOCIAL SECURITY NO		
17. INFORMANT <i>Washington Sanitarium & Hospital Records</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>16x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>BENIGN CARCINOMA WITH METASTASES</i> DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		Address <i>7 days</i>		
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>M.D.</i> (County) (State)
21. I certify that I attended the deceased from <i>July 7, 1950</i> to <i>July 7, 1957</i> that I last saw the deceased alive on <i>July 16, 1957</i> , and that death occurred at <i>5301/1M</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>1113 1/2 Avenue NW</i>		DATE SIGNED <i>July 16, 1957</i>				
ACTUAL SIGNATURE <i>Robert L. Kaufmann</i>		PHYSICIAN'S NAME (Type) <i>ROBERT L. KRICHMAR MD</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 9/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Lebanon Cemetery</i>	22d. LOCATION (City, town, or county) <i>Hagerstown Md</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>John N. Roddy</i>		ADDRESS <i>3501-14 St. N.W.</i>		24. REC'D BY REGISTRAR <i>JUL 9 - 1957</i>		24. REGISTRAR'S SIGNATURE <i>J. John Roddy</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1-2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07631

Reg. Dist. No.

07567

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D.C.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb 2 yrs. 4mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1115 Wisconsin Ave., N.W.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7300 Cedar Haven Rest Home Balt. Ave.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mary E. Jarvis Keely		First	Middle	Lost	4. DATE OF DEATH July 15,	Month	Day	Year
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1867	9. AGE (In years lost birthday) 89 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME -- James		14. MOTHER'S MAIDEN NAME --- Franks						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT William B. Keely- 5312 N. 32nd Street <i>Address</i> Arlington, Virginia				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia							INTERVAL BETWEEN ONSET AND DEATH 15 days	
491X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO								
(c) DUE TO								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 450.0 General arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County)		(State)
21. I certify that I attended the deceased from Dec. 28, 1945 , to July 15, 1957 , that I last saw the deceased alive on July 14, 1957 , and that death occurred at 6:12 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Luther H. Snyder</i> M.D. 915 - 19th Street, N.W. ADDRESS (Street, city or town, state) Washington 6, D.C. DATE SIGNED								
PHYSICIAN'S NAME (Type) Luther H. Snyder								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/18/1957		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Prince Georges County, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.		ADDRESS Wash. D.C.		24a. REC'D BY REG. CLERK 1779		24b. REGISTRAR'S SIGNATURE <i>J. Helen Daddo</i>		

TO HOSPITAL OR ATTENDANT PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V.

DL 17 1957

CEIVEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07632

7657

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 24 days		2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
3. NAME OF DECEASED (Type or print) Ernest		First Laurence		Middle Kendall		4. DATE OF DEATH July 6, 1957		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 5, 1955		9. AGE (In years lost birthday) 1 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
13. FATHER'S NAME Fredric L. Kendall		14. MOTHER'S MAIDEN NAME Barbara Green							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Lymphatic Leukemia DUE TO 204.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 7 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 12, 1957 to July 6, 1957 , that I last saw the deceased alive on July 6, 1957 , and that death occurred at 4:30 PM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Kurt Kohn</i> PHYSICIAN'S NAME (Type) KURT KOHN, M. D.		M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 7/7/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery		22d. LOCATION (City, town, or county) Montgomery County, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren C. W. Humphrey</i>		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 7-10-57		24b. REGISTRAR'S SIGNATURE <i>Beauis McSherry</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 2 & 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

JUL 12 1957

REGISTRAR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08687

212

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Form PM3, Page 2, and to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by you for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		07591		Reg. Dist. No. 212
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)		
a. COUNTY		a. STATE		
Montgomery		Md		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY		
Poolesville		Montgomery		
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
5 yrs		Poolesville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		
Willard Rd		Willard Rd		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	
Walter		Steve	Kidd	
4. DATE OF DEATH		Last	Month Day Year	
July 31 1957		63 yrs	31 1957	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	
Male		White	Divorced <input type="checkbox"/> 7-10-94	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		
Labourer		Farmer		
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Va.		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
W. Kidd		Ann Stevens		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 17. INFORMANT		
Yes		485-00059-230-09-30 Virginia Kidd (wife) Same # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Address		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion		
420.1 DUE TO				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO		
		(c)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
INTERVAL BETWEEN ONSET AND DEATH 20 min.				
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Bronchial asthma - 20 yrs.				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of Item 18]		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE		DATE SIGNED		
EXAMINER'S NAME (Type)		FRANK J. BROSCHART M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION OR REMOVAL (Specify)		22b. DATE THEREOF		
Burial		8/1/57		
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)		
Monocacy		Beallsville Md		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		
William B. Hilton, Beallsville, Md		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE		
		8/1/57 Charles W. Elgin		

BUREAU Y.

AUG 5 1957

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07633

07658

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>New York</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>11 months</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jamestown</i>	
3. NAME OF DECEASED (Type or print) <i>Joseph Charles Kiley</i>		d. STREET ADDRESS <i>101 Maple St.</i>	
4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH <i>July 22 1957</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 25, 1879</i>	
9. AGE (In years last birthday) <i>78 yrs.</i>		10. UNDER 1 YEAR IF UNDER 24 HRS <i>Months Days Hours Min</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Insurance</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>← New York</i>	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edward Kiley</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Ann Gaskin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-12-3285</i>	
17. INFORMANT <i>Eva Kiley Baker 5611 Greentree Rd.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>—</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>—</i> p.m. <i>—</i> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State) <i>—</i>	
21. I certify that I attended the deceased from <i>August 11, 1956</i> to <i>July 8, 1957</i> , that I last saw the deceased alive on <i>July 8, 1957</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>—</i>	
ACTUAL SIGNATURE <i>Allen J. O'Neill</i>		DATE SIGNED <i>July 22, 1957</i>	
PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill</i>		ADDRESS <i>8601 Old Georgetown Rd, Bethesda</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bur.-Transit</i>		22b. DATE THEREOF <i>7/22/57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Lakeview</i>		22d. LOCATION (City, town, or county) <i>Jamestown. New York</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>7-28-57</i>	
		24b. REGISTRAR'S SIGNATURE <i>Bennie M. Thompson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 which is to be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEAU V. 2

JUL 25 1957

REGEV

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07659

CERTIFICATE OF DEATH

07634

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland b. COUNTY		
				Maryland		Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Bethesda 14, Maryland		1 day		Rockville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
				1615 Bradley Avenue				
3. NAME OF DECEASED (Type or print)		First Ned	Middle Edward	Last King	4. DATE OF DEATH	Month July	Day 22, 1957	Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	February 23, 1916	41 yrs	Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Sign Painter		Advertising		Pennsylvania		U.S.A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				
John King				Jennie Sebold				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) yes		16. SOCIAL SECURITY NO.		17. INFORMANT		The Medical Record Address		
		(If known, give name and date of service) WW II		not available		The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		increased intracranial pressure				10 days		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) glottasthma multifaria				10+ days		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
20g. ACTUAL SIGNATURE		<i>Norman H. Price</i>		M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland		
20h. PHYSICIAN'S NAME (Type)		N. H. Bell, M. D.				DATE SIGNED 7/23/57		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)		
Burial		7/25/57		Arlington National		Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
Robert A. Pumphrey		Bethesda, Maryland		DATE 7-24-57		<i>Bessie M. Thompson</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

JUL 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07635

07660 CERTIFICATE OF DEATH

Reg. Dist. No. Q 110

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14232 HOWARD AVE.											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		d. STREET ADDRESS KENSINGTON		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First JOHN Middle FRANKLIN Last KROUSE		4. DATE OF DEATH Month JULY Day 24 Year 1957		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT 2-1881		9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY STORE OWNER		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME GEORGE S KROUSE		14. MOTHER'S MAIDEN NAME ELLA HOLLINGSWORTH		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT CASSIUS KROUSE -BROTHER		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarction		19. INTERVAL BETWEEN ONSET AND DEATH 4 days		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. arteriosclerosis		years									
DUE TO (b)				(c)											
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 450.0								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20g. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) White Not while at work		20c. TIME OF INJURY Month, Day, Year Hour e. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 615 W. Montgomery Ave., Rockville, Md.		(County) Montgomery (State) Md.					
21. I certify that I attended the deceased from July 22, 1957 , to July 24, 1957 , that I last saw the deceased alive on July 23, 1957 , and that death occurred at 6 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Montgomery County, Md.		DATE SIGNED Stephen C. Cromwell											
ACTUAL SIGNATURE Stephen C. Cromwell		PHYSICIAN'S NAME (Type) Stephen C. Cromwell		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 26, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		22d. LOCATION (City, town, or county) Montgomery County, Md.					
22e. FUNERAL DIRECTOR'S SIGNATURE Warren C. Humphrey		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 7-27-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson									

BUREAU V. E.

No. L 1057

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07636

C7661 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5036 Wisconsin Avenue, N. W. 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS Washington, D. C.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Theodore	Middle H	Last Kurtz
4. DATE OF DEATH	Month July	Day 10	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 24, 1892
			9. AGE (In years lost birthday) 65 yrs
			10. IF UNDER 1 YEAR 3 Months
			11. IF UNDER 24 HRS. 16 Days
			Hours
			Min
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock clerk		10b. KIND OF BUSINESS OR INDUSTRY ??	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Kurtz		14. MOTHER'S MAIDEN NAME Louise ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 368-30-9389	
17. INFORMANT X Medical Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Atelectasis		1 hour	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal Obstruction		48 Hours	
DUE TO (c) Carcinoma of Recto-Sigmoid Colon			
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 9, 1957, to July 10, 1957, that I last saw the deceased alive on July 10, 1957, and that death occurred at 1:07 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE P. P. Andrews 7-10-57			
PHYSICIAN'S NAME (Type) P. P. Andrews M. D.		4201 Fessenden St. N. W. Wash. D. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 7/11/1957	
22c. NAME OF CEMETERY OR CREMATORIAL ?		22d. LOCATION (City, town, or county) Detroit (State) Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.		24a. REC'D BY REGISTRAR DATE 7/13/57	
		24b. REGISTRAR'S SIGNATURE Basie M. J. 7-13-57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the funeral director.

RECEIVED
BUREAU V. S.

JUL 19 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07662

CERTIFICATE OF DEATH

07637

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
				a. STATE Alabama	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 49 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Bethesda 14, Maryland				Sipsey	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS None	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Horace	Middle John	Last Land	4. DATE OF DEATH July 10 1957	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1939	9. AGE (In years last birthday) 18 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Alabama	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Talmadge Land		14. MOTHER'S MAIDEN NAME Edna Bland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4211 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) Infected Suture Line 5 wks } DUE TO (c) Traumatic Valvulotomy 5 wks				INTERVAL BETWEEN ONSET AND DEATH 3 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 22, 1957, to July 10, 1957, that I last saw the deceased alive on July 10, 1957, and that death occurred at 1:45 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE John A. Walchhausen M.D. PHYSICIAN'S NAME (Type)				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 7/11/57		22c. NAME OF CEMETERY OR CREMATORIUM --	
22d. LOCATION (City, town, or county) Sipsey, Alabama				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St., N.W.		ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR DATE JUL 12 '57	24b. REGISTRAR'S SIGNATURE Reese Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

MIL 12 1957

REGD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07639
223

07568

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>		d. STREET ADDRESS <u>7309 Willow Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <u>Freedom</u>	Middle <u>Roseee</u>	Last <u>Reaman</u>	4. DATE OF DEATH Month <u>July</u>	Day <u>7</u>	Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1893</u>	9. AGE (In years last birthday) <u>63 yrs.</u>	IF UNDER 1 YEAR Months <u>0</u>	IF UNDER 24 HRS Days <u>0</u>	Hours <u>0</u>	Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>J.S. P.D. Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Isaac Reaman</u>		14. MOTHER'S MAIDEN NAME <u>Minerva Mc Kown</u>							
15. WAS DESEASIDEVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>Not Guard</u>		17. INFORMANT <u>Mrs. Mabel L. Reaman, (same as #2)</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO		Circulatory failure - (shock)		INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b)		DUE TO		Cerebral thrombosis.		2 weeks			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic lymphocytic leukemia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>Aug 1956</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>113 Carroll St NW</u>		20f. (City or town) <u>Washington</u>		(County) <u>D.C.</u>	(State) <u>DC</u>
21. I certify that I attended the deceased from <u>Aug 1956</u> to <u>July 7 1957</u> , that I last saw the deceased alive on <u>July 7 1957</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <u>113 Carroll St NW Washington 12 DC</u>		DATE SIGNED <u>7/7/57</u>	
ACTUAL SIGNATURE <u>James R. Coleman, M.D.</u>		PHYSICIAN'S SIGNATURE <u>JAMES R. COLEMAN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 10, 1957</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) <u>Prince George Co Maryland</u>		(State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Miller</u>		ADDRESS <u>254 Carroll St NW</u>		24. REC'D. BY REGISTRAR <u>GULF</u>		25. REGISTRAR'S SIGNATURE <u>J. Miller, N.D.</u>		DATE <u>7/7/57</u>	

TO HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MIL 10 1957

REG'D & FILED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07640

07663

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE Maryland	
Bethesda 14, Maryland		19 days		b. COUNTY Montgomery	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		The Clinical Center, Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	

3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Mabelle		Odeal	Lewis		July	29,	1957	

5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years (last birthday))	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	December 5, 1882	74 yrs.	Months	Days	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bookkeeper	Government	New York	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Lyman Truman	Mary Beers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland
--	------------------------	--

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		
170x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		2 PULMONARY EMBOLUS
(b) DUE TO		
22 THROMBOEMBOLITIS, OCCLUT.		
(c) DUE TO		
CIRCUMUMA OF RT. BREAST.		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
1164X		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
---	--	--	--	--	--

20c. TIME OF INJURY	Month	Day	Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour a. m. p. m.			19	White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>				

21. I certify that I attended the deceased from July 10, 1957, to July 29, 1957, that I last saw the deceased alive on July 29, 1957, and that death occurred at 5:25A M, from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED 7/29/57
---	---------------------------------------	------------------------

ACTUAL SIGNATURE <i>Allen D. Goodman, MD.</i>	M.D.	The Clinical Center National Institutes of Health Bethesda 14, Maryland
PHYSICIAN'S NAME (Type) Allen D. Goodman, M. D.		

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, county)
Cremation	7/31/57	Cedar Hill Crem	Frederick Rd. Md

23. FUNERAL DIRECTOR'S SIGNATURE <i>Chung Chuan Funeral Home</i>	ADDRESS 5103 3rd Ave Baltimore, Md.	24a. REC'D BY REGISTRAR DATE 7-31-67	24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>
---	---	---	---

HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician. To FURNISH DIRECTOR: After his certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-troulet permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
EUROPEAN

May 22 1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07664

CERTIFICATE OF DEATH

07641

Reg. Dist. No. 216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages A & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY <i>MONTG. CO.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>MONTG.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>17 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>902 Maple Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Nancy</i>	Middle <i>ANX</i>	Last <i>Lewis</i>	4. DATE OF DEATH Month <i>JULY</i>	Day <i>17</i>	Year <i>1957</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-9-77</i>	9. AGE (In years from birthday) <i>80 yrs</i>	10. IF UNDER 1 YEAR Months <i>5</i>	11. IF UNDER 24 HRS. Days <i>4</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>TENN</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>David MORGAN</i>		14. MOTHER'S MAIDEN NAME <i>Luzanna Dodson</i>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>CHART</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary embolus</i>								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>1957x</i>								
(b) DUE TO <i>Adenocarcinoma of pancreas</i>								
(c) DUE TO <i>with hepatic metastases</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month <i>July</i>	Day <i>17</i>	Year <i>1957</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Rockville Md.</i>	(County) <i>Tazwell</i>	(State) <i>Tennessee</i>
21. I certify that I attended the deceased from <i>July 1, 1957</i> , to <i>July 17, 1957</i> , that I last saw the deceased alive on <i>July 17, 1957</i> , and that death occurred at <i>9 AM</i> from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <i>Rockville Md.</i>								
DATE SIGNED <i>7-19-57</i>								
ACTUAL SIGNATURE <i>J. P. McCaprick</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>J. P. McCaprick</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/27/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Woods Cemetery</i>		22d. LOCATION (City, town, or county) <i>Tazwell, Tennessee</i>		
(State) <i>Tennessee</i>								
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda Maryland</i>						
		24a. REC'D BY REGISTRAR DATE <i>7-19-57</i>						
		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>						

BUREAU Y.

May 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07665

CERTIFICATE OF DEATH

07642

Reg. Dist. No. 215

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial transit permit. Then please remove carbon paper. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 33 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1607 Bradley Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Herve		First Joseph	Middle L'HEUREUX	Last L'HEUREUX	4. DATE OF DEATH July 9 1957	Month July	Day 9	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6 March 1899	9. AGE (In years less birthday) 58 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0	Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Rodolphe L'HEUREUX		14. MOTHER'S MAIDEN NAME Pichette Desneiges						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT Official Navy Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)		<i>Cancerous, sigmoid colon with generalized metastasis</i>		INTERVAL BETWEEN ONSET AND DEATH 2 years.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 7 June 1957 , to 9 July 1957 , that I last saw the deceased alive on 9 July 1957 , and that death occurred at 3:10 P.M. from the causes and on the date stated above				ADDRESS (Street, city or town, state) M.D. U.S. Naval Hospital, Bethesda, Md. 7-10-57				
ACTUAL SIGNATURE <i>E.P. Osborne</i>				DATE SIGNED 7-10-57				
PHYSICIAN'S NAME (Type) D. P. OSBORNE, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12 July 1957		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Prendergast</i>		ADDRESS Gawler's & Sons, 1756 Penn Ave., N.W. Wash. D.C.		24a. REC'D BY REGISTRAR DATE 7-10-57		24b. REGISTRAR'S SIGNATURE <i>Mary E. Parrelly</i>		

BUREAU V. E

JULY 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07666 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07643
274

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar, or removal.

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) d. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Glenn			c. LENGTH OF STAY IN 1b 56		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Walter Reed Annex			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		
3. NAME OF DECEASED (Type or print) Jack F. Lindley			First Jack	Middle F.	Last Lindley
4. DATE OF DEATH July 1, 1957	Month July	Day 1	Year 1957		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 12/9/1918	9. AGE (in years (last birthday) 38 yrs.)	IF UNDER 1 YEAR Months 0
8. WIDOWED <input type="checkbox"/>	9. DIVORCED <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) M. Sgt.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army	10c. BIRTHPLACE (State or foreign country) North Carolina
13. FATHER'S NAME John W. Lindley			14. MOTHER'S MAIDEN NAME Ollie McKay		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 238-05-9615	17. INFORMANT Army records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion					
40.1 DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 7/1/57	
EXAMINER'S NAME (Type) Frank J. Broschart	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Select One) SHIPPER	22b. DATE THEREOF 7-3-57	22c. NAME OF CEMETERY OR CREMATORIAL CHARLOTTE N.C.	22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co 1400 Chafin St. #105			ADDRESS Wash D.C.	24a. REC'D BY REGISTRAR 1957	24b. REGISTRAR'S SIGNATURE Laurel Valley

BUREAU V. S.

DEC 5 1957

RECEIVED

07644
223

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07563 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records or for burial, cremation, or removal.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar, or to burial, cremation,

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb D. O. A.		d. STATE Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		e. COUNTY Montgomery		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
f. STREET ADDRESS 600 Dale Drive				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Llewellyn Lowery		First Robert	Middle Llewellyn	Last Lowery	4. DATE OF DEATH July 13 1957
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-93	9. AGE (In years last birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? America					
13. FATHER'S NAME Charles Nicholas Lowery		14. MOTHER'S MAIDEN NAME Mary Ann Devore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT (Wife) Rhea G. Lowery (Sister) 600 Dale Dr. S. S. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 1 hr			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Frank J. Broschart	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 7-13-57
EXAMINER'S NAME (Type) FRANK J. Broschart					
22a. BURIAL, CREMATION, REMOVAL? (Specify) Burial	22b. DATE THEREOF July 15, 1957		22c. NAME OF CEMETERY OR CREMATORIUM George Washington Cemetery Prince George Co. Md.		22d. LOCATION (City, town, or county) (State) Prince George Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Broschart	ADDRESS 259 Carrollton		24a. REG'D BY REGISTRAR DATE 7/15/57		24b. REGISTRAR'S SIGNATURE J. J. Broschart

BUREAU V. S.

JUL 17 1955

RECEIVED

RECEIVED JULY 17 1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07645

07667

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN 1b

14 years

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

200 Granville Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

200 Granville Drive

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
July 28Day
Year
1957

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
lost birthday)
72 yrs.IF UNDER 1 YEAR
Months Days Hours Min.

female

white

WIDOWED DIVORCED

April 9, 1885

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dressmaker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ladies Apparel

Poland

12 CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Stanislaw Dobozinski

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

017-12-1711A Chester F. Bernard, 200 Granville St., SS., Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Carcinoma of breast with metastasis

INTERVAL BETWEEN
ONSET AND DEATH

3 1/2 years

MEDICAL CERTIFICATION

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

Pneumonia

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m.20d. INJURY OCCURRED
White Nat white
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from January 1952, to 28 July, 1952, that I last saw the deceased alive on 28 July, 1952, and that death occurred at 10:45 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Seruch T. Kimble

M.D.

929 Pemberly Dr., Silver Spring,
Md. 20901PHYSICIAN'S
NAME (Type)

SERUCH T. KIMBLE

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Aug. 1, 1957

22c. NAME OF CEMETERY OR CREMATORI

St. John's Cemetery

22d. LOCATION (City, town, or county)

Forest Glen, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Warren G. Humphrey

ADDRESS

Silver Spring, Md.

24a. REC'D BY REGISTRAR

DATE 7/28/57

24b. REGISTRAR'S SIGNATURE

Frances Totter

JUL 3 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07592

CERTIFICATE OF DEATH

07646
213

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived; if institution, residence before admission) a. STATE <i>Washington, D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>	c. LENGTH OF STAY IN lb <i>1b</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>University of Maryland Hospital</i>		d. STREET ADDRESS <i>3717 1/2 N. Capital St., N.W.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Nettie E. Lyon</i>	First	Middle	Last
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>10/10/1878</i>
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) <i>86 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
10c. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John W. Lyon</i>		14. MOTHER'S MAIDEN NAME <i>Ida E. Lyon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Robert E. Lyon (Husband)</i>		Address <i>1150 Coosa Ave Washington 6, D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>332x</i>			
(b) DUE TO <i>Cerebral arteriosclerosis</i>		10 years	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Atrial fibrillation</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct. 22nd, 1947</i> to <i>July 6th, 1957</i> , that I last saw the deceased alive on <i>July 5th, 1957</i> , and that death occurred at <i>8:15 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. E. Lyon Dunn</i> PHYSICIAN'S NAME (Type) <i>R. E. Lyon Dunn</i>		ADDRESS (Street, city or town, state) <i>1150 Coosa Ave Washington 6, D.C.</i> DATE SIGNED <i>7/6/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>7/8/1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>CONGRESSIONAL CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>WASHINGTON, D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>MARTIN W. KYSNG COMPANY</i>		ADDRESS <i>1300 N. STREET, N.W. WASHINGTON, D.C.</i>	24a. REC'D BY REGISTRAR DATE <i>JULY 11, 1957</i>
			24b. REGISTRAR'S SIGNATURE <i>Lowell Keyser</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 4

NOV 22 1957

KEGEIVIE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 fil 1 - 7 st

07647

Reg. Dist. No.

7/13

07570

CERTIFICATE OF DEATH

PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Prince Georges</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>5 mos.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MT Rainier</i>		d. STREET ADDRESS <i>4408 30th St</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>CEDAR HAVEN REST Home</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Lavenia T</i>		First	Middle	Lost	4. DATE OF DEATH <i>JULY 27</i>	Month	Day	Year <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>OCT 11 1874</i>	9. AGE (In years last birthday) <i>83 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11 BIRTHPLACE (State or foreign country) <i>VA.</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>		
13. FATHER'S NAME <i>Ralph Campbell</i>		14. MOTHER'S MAIDEN NAME <i>Isabella</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Tot. no. or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Isabell Cox daughter</i>		Address <i>4408 30th St, Mt Rainier Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>itself</i>		DUE TO <i>Heart Block with Cardiac Arrest</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <i>Arteriosclerotic Heart Disease</i>		5 years				
(c)		<i>Generalized Arteriosclerosis</i>		8 years				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Cerebral Thrombosis old.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>3513 Kenly St</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		(County) (State)		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>3513 Kenly St</i>		20f. (City or town) <i>MT Rainier</i>				
21. I certify that I attended the deceased from <i>April 1, 1957</i> to <i>July 27, 1957</i> , that I last saw the deceased alive on <i>July 27, 1957</i> , and that death occurred at <i>2:45 AM</i> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <i>3513 Kenly St</i>								
DATE SIGNED <i>7/27/57</i>								
ACTUAL SIGNATURE <i>Norman Donat Pomeau</i>		PHYSICIAN'S NAME (Type) <i>Norman Donat POMEAU</i>		22. NAME OF CEMETERY OR CREMATORIUM <i>Mt Rainier</i>		22d. LOCATION (City, town, or county) <i>Colmar Manor, Md.</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/30/57</i>		22c. ADDRESS <i>Mt Rainier Md.</i>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nakayama Funeral Home Inc.</i>		24a. REC'D BY REGISTRAR DATE <i>31 1957</i>		24b. REGISTRAR'S SIGNATURE <i>J. Blundell</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

JUL 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07668

CERTIFICATE OF DEATH

07648
215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 22 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 5 Alder Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Stephen	Middle Frances	Last MALICKI	4. DATE OF DEATH	Month July	Day 8	Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-3-55	9. AGE (In years last birthday) 1 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Tadeus Malicki				14. MOTHER'S MAIDEN NAME Claire Clarke				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mother, Claire Malicki (Same As #2)		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Metastatic Neuroblastoma</i>		DUE TO				INTERVAL BETWEEN ONSET AND DEATH 3 months		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 16 June 1957 to 8 July 1957 that I last saw the deceased alive on 8 July 1957 , and that death occurred at 3:05 P.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state)								
DATE SIGNED								
ACTUAL SIGNATURE <i>John H. Mazur</i>		M.D. U.S. Naval Hospital, Bethesda, Md. 7-957						
PHYSICIAN'S NAME (Type) JOHN H. MAZUR, LT. MC, USN		U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-10-57		22c. NAME OF CEMETERY OR CREMATORIAL Annapolis Nat'l Cemetery		22d. LOCATION (City, town, or county) Annapolis, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons, Annapolis, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE 7-9-57		
						24b. REGISTRAR'S SIGNATURE <i>Henry E. Casselly</i>		

RECEIVED
BUREAU V. S.

JUL 10 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07669

CERTIFICATE OF DEATH

07649
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 43 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 715 Highwood Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First James	Middle Thomas	Last MANNION	4. DATE OF DEATH	Month July	Day 23	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 5, 1897	9. AGE (In years last birthday) 59 yrs	10. IF UNDER 1 YEAR Months 59	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas P. MANNION			14. MOTHER'S MAIDEN NAME Delia GILLESPIE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I & II		17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 June 1957 , to 23 July 1957 , that I last saw the deceased alive on 22 July 1957 , and that death occurred at 3:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED John E. Carley							
ACTUAL SIGNATURE John E. Carley							
NAME (Type) John E. Carley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 26 July 1957		22c. NAME OF CEMETERY OR CREMATORIUM Falvo Nat'l Cem.		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. Liston Wiederfield, Greenmount & 22nd		ADDRESS Baltimore, Md.		24a. REC'D BY REGISTRAR 7-23-57		24b. REGISTRAR'S SIGNATURE Mary E. Parcell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UL 94 1957

REVISED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07670

CERTIFICATE OF DEATH

Reg. Dist. No.

17650

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X	
3. NAME OF DECEASED (Type or print) Maria San Nicholas MATEO		d. STREET ADDRESS 9 Cargo Green	
		4. DATE OF DEATH July 13 1957	Month Day Year
5. SEX Female	6. COLOR OR RACE Maylayan	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH February 26, 1921
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 30 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Anesthetist		10b. KIND OF BUSINESS OR INDUSTRY Medicine	
11. BIRTHPLACE (State or foreign country) Guam		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Pedro C. MATEO		14. MOTHER'S MAIDEN NAME Rosa ALVERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
		17. INFORMANT Brother, Juan San Nicholas MATEO (Same as #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 3 wks	
591X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Hyperfervor, Arteritis, myeloneuritis 1 yrs	
DUE TO (c)		Possible chronic glomerulonephritis 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 11, 1957, to July 13, 1957, that I last saw the deceased alive on July 13, 1957, and that death occurred at 5:26 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE William B. Ingram, U.S. Naval Hospital, Bethesda, Md. 7-14-57		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) William B. INGRAM, CDR MC USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-29-57	
22c. NAME OF CEMETERY OR CREMATORIAL Private Cemetery		22d. LOCATION (City, town, or county) (State) Pigo, Guam (Marianas Islands)	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR ADDRESS DATE 7-15-57	
		24b. REGISTRAR'S SIGNATURE Barry E. Garey	

HOSPITAL OR ATTENDANT PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEGELIVED
MILITARY

UL 1 15

V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
0767 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07651
214

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt exists concerning the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or rental.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
<i>Montgomery</i>		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
<i>Silver Spring</i>		7 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
2710 Fenimore Rd		2710 Fenimore Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Bear</i>		<i>Mary</i>	<i>May</i>
4. DATE OF DEATH		Last	Month Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
<i>Female</i>		<i>White</i>	<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>
9. AGE (In years, all birthday)		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>51 yrs.</i>			<i>Va</i>
12. CITIZEN OF WHAT COUNTRY?			
<i>U.S.A.</i>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Wm H. Woodward</i>		<i>Virginia Sommers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT	
<i>No</i>		<i>Jose May (Husband) Son # 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
<i>Coronary occlusion</i>		<i>Sudden</i>	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
DUE TO		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED	
ACTUAL SIGNATURE <i>Frank J. Breschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Breschart</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL/CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>BURIAL</i>		<i>7-5-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
<i>COLUMBIA CEMETERY</i>		<i>ARLINGTON, VA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>DEAL FUNERAL HOME</i>		<i>4812 GAFFE ST. WASHINGTON, D.C.</i>	
24a. REG'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
		<i>Lorraine Miller</i>	
DATE <i>JUL 1</i>			

SUREAU V. S

11 - 1951

DEGEIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07652

07672

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page _____ may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 23 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia		b. COUNTY					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		f. STREET ADDRESS N.W. 4000 Massachusetts Avenue,		g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X		h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ivy		First Amália		Middle MC CULLOUGH		4. DATE OF DEATH September 24, 1957		Month July		Day 4		Year 1957	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 24, 1903		9. AGE (in years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Oscar MEYER		14. MOTHER'S MAIDEN NAME Lilly GRIEMAN											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Husband) Harry Ross MC CULLOUGH (Same as #2)		Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 157X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) DUE TO (c)		Pulmonary atelectasis + widespread metastases Carcinoma, pancreas		INTERVAL BETWEEN ONSET AND DEATH 4 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hepatic failure due to metastases.												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Hour a. m. p. m.		Month 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Md. U.S. Naval Hospital, Bethesda, Md.		(County)		(State)	
21. I certify that I attended the deceased from June 11, 1957, to July 4, 1957, that I last saw the deceased alive on July 4, 1957, and that death occurred at 8:05 AM, from the causes and on the date stated above												ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE George W. Russell												DATE SIGNED 7-4-57	
PHYSICIAN'S NAME (Type) George W. RUSSELL, CAPT, MC, USN/U.S. Naval Hospital, Bethesda, Md.													
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 7-5-57		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		22d. LOCATION (City, town, or county) Prince Georges Co. Maryland		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, Jr.		ADDRESS R.A. Pumphrey, Jr., 7557 Wisc. Ave., Bethesda, Md.		24. REC'D BY REGISTRAR DATE 7-4-57		24b. REGISTRAR'S SIGNATURE Mary E. Barrely,							

BUREAU Y 8

JUL 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07653

.223

Reg. Dist. No.

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 2 should be filed with the coroner prior to burial or cremation or removal and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland SIXTYEIGHT							
Montgomery County				b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Takoma Park, Md.		25 minutes		56 Silver Spring							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 948 B Northhampton Drive						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Washington Sanitarium & Hospital											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
William Perry McManaway					July	24	19	57			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B DATE OF BIRTH	9. AGE (In years lost, birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS				
Male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11-28-14	42 yrs.	Months	Days	Hours	Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?				
pressman		Newspaper		Ohio			U.S.A.				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Charles McManaway		Emma Morris									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO		17. INFORMANT		Address					
		277-03-5827		Hospital Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion						INTERVAL BETWEEN ONSET AND DEATH Terminal-1			
H.I.N. 1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		Coronary Disease & Heart Surgery						2 yrs ago			
DUE TO (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDEPPLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>7/24</u> , 19 <u>57</u> , to <u>7/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/24</u> , 19 <u>57</u> , and that death occurred at <u>6:35 AM</u> , from the causes and on the date stated above.								ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <u>Robert A. Hare</u>		M.D.						DATE SIGNED <u>7/24/57</u>			
PHYSICIAN'S NAME (Type)		Takoma Park, Md.						Released by Dr. Ball - Cora			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)			
Ship & burial		7/24/57		Midway Cemetery		Midway, Ohio					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS						24. REG'D. DATE	25. REG'D. DATE	REGISTRAR'S SIGNATURE	
Warren E. Tempelby 8434 1/2 Silver Spring, Md.		JUL 25 1957								G. Gibson Deek	

BUREAU V.

JUL 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07654

(7673) CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		c. LENGTH OF STAY IN b. 20 Years		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FREDERICK		First	Middle W.	Last Mc.REYNOLDS	4. DATE OF DEATH July 6 1967	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. II 1871	9. AGE (In years last birthday) 85 yrs	10. IF UNDER 1 YEAR Months	Days	11. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lafayette Emerson Mc.Reynolds		14. MOTHER'S MAIDEN NAME Mary Bell Wilson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Jessie B. McReynolds		Address Sandy Spring			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Hypertensive Pneumonia.</i>		INTERVAL BETWEEN ONSET AND DEATH 1 day			
		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<i>Chronic Hypertension</i>		Yes			
		(b)		<i>Posterior Dendritic Heart Disease</i>		No			
		(c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Sandy Spring		(County) Md.	(State) Md.
21. I certify that I attended the deceased from 1 May , 1957, to 6 July , 1957, that I last saw the deceased alive on 6 July , 1957, and that death occurred at 10:30 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Sandy Spring Md.							
ACTUAL SIGNATURE <i>C. H. Liggin</i>		DATE SIGNED 7/8/56							
PHYSICIAN'S NAME (Type) C. H. Liggin		M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 10		22c. NAME OF CEMETERY OR CREMATORIAL Friends Cemt		22d. LOCATION (City, town, or county) Sandy Spring		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ray W Barber</i>		ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR 8-10-57		24b. REGISTRAR'S SIGNATURE <i>Gertrude B Lawyer</i>			

MEAU V. S

NOV 17 1957

REGELIVE

TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a Burial-Transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**FOR STATE
HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07655

Reg. Dist. No. 216

07674

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if not in residence before admission) a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Plains	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3112 Leland St.		d. STREET ADDRESS 4 Hilton Ave.		e. L.R.S. [] ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Stanton Merithew		First	Middle	Last	Date of Death July 4, 1957
4. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4/7/1905	9. AGE [In years last birthday] 52 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automotive engineer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.Y.	
13. FATHER'S NAME A. Floyd Merithew		14. MOTHER'S MAIDEN NAME Gertrude P. Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 023-05-7810		17. INFORMANT Mrs. Geo. R. Titus (sister) Item 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH sudden					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White or work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/4/57	
22a. BURIAL, CREMATION REMOVAL (Specify) CREMATION		22b. DATE THEREOF 7/5/57		22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CREMATORIUM	
22d. LOCATION (City, town, or county) PRINCE GEORGE COUNTY, MARYLAND		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Humphrey</i>		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 7-5-57	
				24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

RECEIVED
MAY 19 1968
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

(7675)

CERTIFICATE OF DEATH

07656

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 8009 Custer Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Richard	Middle Norman	Last MEYER	4. DATE OF DEATH	Month July	Day 29	Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 November 1910	9. AGE (in years last birthday) 46 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Phillip C. MEYER				14. MOTHER'S MAIDEN NAME May Hyman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Yes		16. SOCIAL SECURITY NO. WW-II		17. INFORMANT Unknown		Address (Wife) Mrs. Madeleine C. Meyer (Same As #2)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								INTERVAL BETWEEN ONSET AND DEATH indefinite
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20c. TIME OF INJURY Hour a. m. p. m.	Month July	Day 29	Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) Arlington Nat'l Cemetery	20f. (City or town) Arlington	(County) Virginia	(State) Virginia
21. I certify that I attended the deceased from 24 July , 1957, to 29 July , 1957, that I last saw the deceased alive on 29 July , 1957, and that death occurred at 10:45A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 7-29-57								
ACTUAL SIGNATURE <i>J.T. Horgan</i>	MD. U.S. Naval Hospital, Bethesda, Md. 7-29-57							
PHYSICIAN'S NAME (Type) J.T. HORGAN, LT, MC, USN	U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1 August 1957	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) Arlington, Virginia	(State) Virginia				
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphrey</i>	ADDRESS 7551 Wisconsin Ave., Bethesda, Md.	24a. REC'D BY REGISTRAR Bray & Farrelly	24b. REGISTRAR'S SIGNATURE <i>Bray & Farrelly</i>	DATE 7-29-57				

RECEIVED
BUREAU NO. 1

JUL 31 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07676 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07657
11-11-

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10,007 Loraine Ave.				d. STREET ADDRESS 4918 3rd St., N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last HELEN HOWARD MILLER		4. DATE OF DEATH JULY 11 1957					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH JULY 30, 1899	
9. AGE (in years last birthday) 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TPM Operator - Government Services, Inc.		11. BIRTHPLACE (State or foreign country) HOWARDVILLE, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR W. STUDDS				14. MOTHER'S MAIDEN NAME ANNA E.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 577-10-7219		17. INFORMANT Mr. Farnham R. Miller, 10,007 Lorain Ave. Silver Spring, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH sudden			
(b) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u>							
(c) <u>DUE TO</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) FRANK J. BROSCHEART		7/11/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/15/57		22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L. CEMET'RY		22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA	
(State)				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frances Koller</i>		ADDRESS ST. SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 7-17-57		24b. REGISTRAR'S SIGNATURE <i>Frances Koller</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DECEMBER
1970

1970

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07658

Reg. Dist. No. 217

(767)

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Washington		b. COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookmont		c. LENGTH OF STAY IN lb ??		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 620 E Street, S. W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) C & O Canal				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Morton	Middle Ray	Last MILLER	4. DATE OF DEATH 9/6/41	Month July	Day 7	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/6/41	9. AGE (in years last birthday) 15 yrs.	IF UNDER 1YEAR 9 months	IF UNDER 24 HRS. 21 hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Morris Miller		14. MOTHER'S MAIDEN NAME Alice William					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Alice Teresi- Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia INTERVAL BETWEEN ONSET AND DEATH Sudden							
J 92,98 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Drowning							
DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) apparently drowned while swimming in Canal					
20c. TIME OF INJURY ? Hour o. m. p. m.		Month, Day, Year 7/7/ 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) C & O Canal	20f. (City or town) Brookmont	(County) Montg.	(State) Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED July 8, 1957
EXAMINER'S NAME (Type) Frank J. Broschart, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/10/57	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		22d. LOCATION (City, town, or county) Suitland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS 		24a. REC'D. BY REGISTRAR DATE 7/12/57	24b. REGISTRAR'S SIGNATURE Gertrude Lawler		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, telegraph to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or removal agent.

FBI BUREAU V. S.

JUL 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07659
218
Reg. Dist. No.

7678

CERTIFICATE OF DEATH

1. PLACE OF DEATH o COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. LENGTH OF STAY IN 1b 6 Mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander Rest. Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Pearl	Middle M.	4. DATE OF DEATH July 29
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10-1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Snow Hill, Md
13. FATHER'S NAME George S. Mills		14. MOTHER'S MAIDEN NAME Mattie Nash	12. CITIZEN OF WHAT COUNTRY Address Bethesda, Md
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	17. INFORMANT Mr. Harry Black 45298 Lehighwood Lane
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 13 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 		DUE TO (c) 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-12 , 19 52 , to 7-29 , 19 52 , that I last saw the deceased alive on 7-26 , 19 52 , and that death occurred at M. , from the causes and on the date stated above ADDRESS (Street, city or town/state) Lehighwood Lane, Bethesda, Md. DATE SIGNED Aug 1, 1952			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) James P. Kerr		M.D.	
22a. BURIAL, CREMATION, BURIAL SPECIFY)	22b. DATE THEREOF 7-31-57	22c. NAME OF CEMETERY OR CREMATORIAL Bethesda Methodist	22d. LOCATION (City, town, or county) (State) Snow Hill, Md
23. FUNERAL DIRECTOR'S SIGNATURE Clay E. Dennis		24a. REC'D. BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE Alverda Corker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3, to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

JULG 1 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07572

CERTIFICATE OF DEATH

07660
770
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE D. C.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK, MD.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		4 7 A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fair Hill Rest Home</i> 207 HUDSON AVENUE		d. STREET ADDRESS 1852 Columbia Rd. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KATHERINE		First G.	Middle MIXER	Last 7	DATE OF DEATH Month	Day 5	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> March 29, 1873	9. AGE (in years last birthday) 84	10. IF UNDER 1 YEAR Months Address 1852 Columbia Rd. N.W.	11. IF UNDER 24 HRS Days Washington, DC	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Evansville, Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Bradley Graham		14. MOTHER'S MAIDEN NAME Elizabeth M. Gooldy					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Winifred H. Johnson		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>	
no						INTERVAL BETWEEN ONSET AND DEATH 15 minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Arteriosclerotic Heart Disease</i>		(b)		(c)		5 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p. n. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1852 Columbia Rd. N.W.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 1, 1950 July 5, 1957</i> that I last saw the deceased alive on <i>July 3, 1957</i> , and that death occurred at <i>6:45 PM</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Horace H. Custis, Jr.</i> PHYSICIAN'S NAME (Type) Horace H. Custis, Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/9/57		22c. NAME OF CEMETERY OR CREMATORIUM Glenwood Cemetery		22d. LOCATION (City, town, or county) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company		ADDRESS Washington, DC		24a. RECD BY REGISTRAR JUL 8 1957		24b. REGISTRAR'S SIGNATURE <i>J. Hines Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 ■ FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

111 A 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07661

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 2 hr. 36 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencerville		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) (Girl)	First	Middle	Last	4. DATE OF DEATH MOODY	July	Month 13	Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/13/57	9. AGE (In years lost birthday) yrs	IF UNDER 1 YEAR IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) New Born		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	Months 2	Days 30	12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Robert A. Moody				14. MOTHER'S MAIDEN NAME Anne Shirley Gardner				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Anne Shirley Moody		Address Spencerville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Alektokin (new born)</u> INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>prematurity, 28 weeks</u> DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Sykesville	(County) Maryland	(State) MD
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on <u>July 13, 1957</u> , and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Bertram R. Gau</u> M.D. ADDRESS (Street, city or town, state) <u>Sykesville Maryland</u> DATE SIGNED <u>7-13-57</u>								
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF July 15/57		22c. NAME OF CEMETERY OR CREMATORIAL Spencerville		22d. LOCATION (City, town, or county) Spencerville (State) MD		
23. FUNERAL DIRECTOR'S SIGNATURE Roy W Barber		ADDRESS Spencerville		24a. REC'D BY REGISTRAR 7/16/57		24b. REGISTRAR'S SIGNATURE Gwendolyn Landry		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-permit. Then please remove carbon papers. Pages 1, 2 should be filed with the register or prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 23 1952

REGELVÉD

4-11
11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07662

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney	c. LENGTH OF STAY IN 1b 10 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencerville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General		d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) (Baby Girl)	First Moody	Middle Moody	4. DATE OF DEATH July 21 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13 1957			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) # # # # #		10b. KIND OF BUSINESS OR INDUSTRY # # # # #	11. BIRTHPLACE (State or Foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Robert A. Moody		14. MOTHER'S MAIDEN NAME Anne Shirley Gardner				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) if		16. SOCIAL SECURITY NO. ###	17. INFORMANT Robert A. Moody			
		Address Spencerville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 774X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH 8 days				
(b) Blood dyscrasia + malnutrition						
(c) Prematurity (28 weeks)						
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) SYKESVILLE	(County) Maryland	(State) 7/21/57
21. I certify that I attended the deceased from 7-13-1957 to 7-21-1957 , that I last saw the deceased alive on 7-20-1957 , and that death occurred at 2:48 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SYKESVILLE Maryland						
ACTUAL SIGNATURE Bertrand R. Gau		DATE SIGNED 7/21/57				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 23 57	22c. NAME OF CEMETERY OR CREMATORIUM Union	22d. LOCATION (City, town, or county) Burtonsville		
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber		ADDRESS Laytonsville, Md.	24a. REC'D BY REGISTRAR DATE 7-23-57			
			24b. REGISTRAR'S SIGNATURE Levinda B. Lawler			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
 Page 31 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar.

RECEIVED

JUL 26 1957

REAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07681

CERTIFICATE OF DEATH

Reg. Dist. No.

07663
214

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 17 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 303 Granville Drive		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 303 Granville Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Frances Zimmerman Moore		First	Middle	Last	4. DATE OF DEATH July 24	Month	Day	Year 19 57
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1893	9. AGE (in years last birthday) 63 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (State or foreign country) Paola, Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME George W. Zimmerman		14. MOTHER'S MAIDEN NAME Laura J. Scaritt						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 4 hrs				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		(b) Generalized arteriosclerosis		10 yrs				
DUE TO (c) Hypertension				15 yrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from _____ June 15, 1957 to July 23, 1957, that I last saw the deceased alive on _____ July 18, 1957, and that death occurred at 3:04 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Arthur H Lewis</i> PHYSICIAN'S NAME (Type) ARTHUR H LEWIS		M.D.		ADDRESS (Street, city or town, state) 1714 R.I. Ave NW WASHINGTON DC				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 26, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Prince George's Co., Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren C. Humphrey</i>		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 7-25-57		24b. REGISTRAR'S SIGNATURE <i>John C. Smith</i>		

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician to be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

RUREAU Y. S

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07664

(7682)

CERTIFICATE OF DEATH

Reg. Dist. No. 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial. Cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN lb 7 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D.C.		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON		f. STREET ADDRESS 2938 MCKINLEY ST. NW		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE EARNEST MOORE		First GEO	Middle EARNEST	Last MOORE	4. DATE OF DEATH JULY 24 1957	Month JULY	Day 24	Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MAR 24-1894	9. AGE (in years from birthday) 63 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISPLAY DEPT.		10b. KIND OF BUSINESS OR INDUSTRY DRUG STORE		11. BIRTHPLACE (State or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME ANTHONY BURTON MOORE		14. MOTHER'S MAIDEN NAME JOHANNA AGUSTA AMREIN							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 577-05-5160		17. INFORMANT ELSIE MOORE - WIFE		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO cause (b), stating the under- lying cause last. (c)		Coronary Artery Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 7 days					
		Coronary Artery Sclerosis		2-3 years					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Post-Breastectomy - 3 weeks				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Under nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5516 Neb. Ave DC		(County) Falls Church, Virginia			
20f. (City or town) DC						(State) 7-28-57			
21. I certify that I attended the deceased from July 17 1957 to July 24 1957 , that I last saw the deceased alive on July 23, 1957 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 5516 Neb. Ave DC		DATE SIGNED 7-28-57			
ACTUAL SIGNATURE Robert B. Havell									
PHYSICIAN'S NAME (Type) Robert B. Havell									
22a. BURIAL, CREMATION, REBURYING OR DISPOSAL burial		22b. DATE THEREOF 7/27/57		22c. NAME OF CEMETERY OR CREMATORIUM Nat. Mem. Park Cemetery		22d. LOCATION (City, town or county) Falls Church, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.		ADDRESS Wash. DC		24a. REC'D BY REGISTRAR JUL 25 1957		24b. REGISTRAR'S SIGNATURE Bevad Thompson			

BUREAU V.

JUL 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07665

216

7683

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 which is to be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
f. STREET ADDRESS 835 Florida Avenue, N. E.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Herbert	Middle Powell	Last Murphy
4. DATE OF DEATH	Month July	Day 17	Year 1957
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 7, 1902
9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS Days 8	12. Hours 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Laborer	10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert Murphy	14. MOTHER'S MAIDEN NAME Mary C. Hall		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Erosion of engorged blood vessel by Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Carcinoma & Esophagus with metastasis DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 8 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 7, 1957 , to July 17, 1957 , that I last saw the deceased alive on July 17, 1957 , and that death occurred at 5:15 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center M.D. 7/17/57			
ACTUAL SIGNATURE Theodore Robinson		PHYSICIAN'S NAME (Type) Theodore Robinson, M. D.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial 7-22-57		22b. DATE THEREOF Lincoln Mem	22c. NAME OF CEMETERY OR CREMATORIAL Lincoln Mem
22d. LOCATION (City, town, or county) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Faylie's Funeral Home 89 L St NW		24a. ADDRESS JUL 22 1957	24b. REGISTRAR'S SIGNATURE Bessie Thompson

BUREAU V.

JUL 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07666
215.

07684

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 23hr. 40 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 5 Cargo Green, S.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Joseph	Middle Jude	Last MURPHY	4. DATE OF DEATH 29 July 1957	Month July	Day 29	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 29 July 1957	9. AGE (in years last birthday) yrs. 23	IF UNDER 1 YEAR Months 23	IF UNDER 24 HRS. Hours 40	Min. 40
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Paul Vincent MURPHY				14. MOTHER'S MAIDEN NAME Joyce Elaine BOLGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Paul V. MURPHY (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c) <i>Immaturity</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 July 1957 , to 29 July 1957 , that I last saw the deceased alive on 29 July 1957 , and that death occurred at 11:50P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 7-30-57							
ACTUAL SIGNATURE <i>Russell Miller, Jr.</i> M.D. PHYSICIAN'S NAME (Type) Russell Miller, Jr., LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-31-57		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert J. Lumpfrey</i> R.A. Lumpfrey, 7551 Wisconsin Ave., Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR 7-30-57		24b. REGISTRAR'S SIGNATURE <i>Harry E. Farrelly,</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

AUG 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07667

223

07573

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 16 3 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Oak, Silver Spring		d. STREET ADDRESS Boeteler Road					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. Christianson's Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Lepha Estelle Neely		First	Middle	Last	4. DATE OF DEATH July	Month	Day 16	Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1877		9. AGE (In years last birthday) 79	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. MIN 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) St. Joseph, Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Jacob Coons		14. MOTHER'S MAIDEN NAME Martha Freeman									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Wm. H. Neely, 10,032 Dallas Ave., Silver Spring, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 5 days					
33IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Senile Arterosclerosis Generalized		DUE TO (b)				10 years					
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pressure Necrosis of Hip and both Heels.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 812 P.M.		20f. (City or town) 7112 Willow Ave		(County) Takoma Park, Md.		(State) 1957	
21. I certify that I attended the deceased from May , 1957, to 16 July , 1957, that I last saw the deceased alive on 15 July , 1957, and that death occurred at 812 P.M. , from the causes and on the date stated above.											
SIGNATURE G. P. Queen		M.D.								DATE SIGNED 17 July	
PHYSICIAN'S NAME (Type) G. P. Queen											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 19, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Suitland, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Walter C. Humphrey		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 7/19/57		24b. REGISTRAR'S SIGNATURE J. Nelson Dodd					

BUREAU X-8

MAY 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07668

07685

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 1 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		d. STREET ADDRESS Rt. #1		e. DATE OF DEATH July		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Jacob	Middle Peter	Last Nehouse	Month	Day	Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/8/84	9. AGE (In years lost birthday) 73 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Henry Nehouse		14. MOTHER'S MAIDEN NAME Annie Hager		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-01-1707		17. INFORMANT Hospital Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not wh. at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 11:45PM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>G. F. Meadors, Jr.</i> ADDRESS (Street, city or town, state) Cedar Grove, Md. DATE SIGNED 7/2/57								
PHYSICIAN'S NAME (Type) G. F. Meadors, Jr., M. D.		Damascus, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 4, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Salem Methodist		22d. LOCATION (City, town, or county) (State) Cedar Grove, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Oliver L. Molsmith</i>		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE 7-6-57		24b. REGISTRAR'S SIGNATURE <i>Lestrange B. Lawler</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TRUDEAU V. S

JUL 12 1971

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 on the back of this certificate as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 07669 216			
Item 1 Film G217 7-16-57 et CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.					b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 2 Bethesda							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6425 Kenhowe Drive, Bethesda					d. STREET ADDRESS 6425 Kenhowe Drive					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First WILLIAM			Middle Newton		Last		4. DATE OF DEATH July 4, 1957	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 17, 1865		9. AGE (In years last birthday) 92 yrs		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Miner			11. BIRTHPLACE (State or foreign country) Manchester, England			12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME John Newton					14. MOTHER'S MAIDEN NAME Sarah Davies								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Dorothy Rizzo, 6425 Kenhowe Drive, Bethesda, Md.				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)		
21. I certify that I attended the deceased from July 25, 1957 , to July 26, 1957 , that I last saw the deceased alive on July 25, 1957 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.												ADDRESS (Street, city or town, state) 816 GEORGIA DR. RO 7/8/57	
ACTUAL SIGNATURE J. J. DONOVAN		DATE SIGNED 7/8/57											
PHYSICIAN'S NAME (Type) LEO J. DONOVAN MD		BETHESDA '57											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/57		22c. NAME OF CEMETERY OR CREMATORIAL Nesquallywood Park		22d. LOCATION (City, town, or county) Bellevue, WA		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Henry Chase Funeral Home, Inc.		ADDRESS 5102 W. 15th Ave		24a. REC'D BY REGISTRAR DATE 7-8-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson							

RECEIVED
BUREAU V. S.

JUL 10 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07670

Reg. Dist. No. 216

(768)

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 16 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X-1 Bethesda				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				d. STREET ADDRESS 7800 Marion Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Maude Smithdeal Norma n		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 12/22/1879	9. AGE (in years last birthday) 77 yr.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Smithdeal		14. MOTHER'S MAIDEN NAME Laura Smith						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Address		

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Bilateral Broncho pneumonia		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause first.		(b) Subdural hematoma & cerebral laceration		2 wks.
DUE TO (a)		(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
---	--	---

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down cellar steps					
20c. TIME OF INJURY Hour 1.00 p.m	Month, Day, Year 7/16/57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) Bethesda	(County) Montg. Md.	(State)

21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry , and find the death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

MEDICAL CERTIFICATION

ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGN 7/29/57		
EXAMINER'S NAME (Type) Frank J. Broschart				
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 7/29/57	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill	22d. LOCAT OF (City, town, or county) Suitland, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE 7-29-67	24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

BUREAU V. S

115 1 1

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

07671

(7688)

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 1 Mo. 6 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 3343 Nichols Ave., S.E.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Cornelius	Middle Edward	4. DATE OF DEATH O'BRIEN	Month July	Day 22	Year 19 57

5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 2 November 1900	9. AGE (In years lost birthday) 56 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.	

13. FATHER'S NAME Patrick O'BRIEN	14. MOTHER'S MAIDEN NAME Mary Sugrue		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WW 1 & II	17. INFORMANT Unknown	Address Official Navy Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Intercanal metastatic carcinoma</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <i>Squamous cell carcinoma right paranasal sinus (larynx)</i>		INTERVAL BETWEEN ONSET AND DEATH 30 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 17 June, 1957, to 22 July, 1957, that I last saw the deceased alive on 22 July, 1957, and that death occurred at 1:35 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE Blair M. Webb M.D. U.S. Naval Hospital, Bethesda, Md. 7-23-57

POLICIAN'S NAME (Type) Blair M. Webb, LT MC, USN U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7-26-57 22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery 22d. LOCATION (City, town, or county) (State) Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines Co ADDRESS S.H. Hines, 2901 14th St., NW, Washington, D.C. 24a. REC'D BY REGISTRAR Mary E. Parrelly 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly DATE 7-23-57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

JUL 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 File No. 7-20-57 et
07689

07672

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmon Sanitarium & Hospital</u>		d. STREET ADDRESS <u>5517 Hoover St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>Margaret</u>	Middle <u>Frances</u>	Last <u>O'Neill</u>	4. DATE OF DEATH	Month <u>July</u>	Day <u>21</u>	Year <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 Sept 1881</u>	9. AGE (In years lost birthday) <u>75 1/2</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward J. O'Neill</u>		14. MOTHER'S MAIDEN NAME <u>BRIDGET GALIVAN</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <u>BETHESDA, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident (Thrombosis)</u>		DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Hypertensive Arterosclerotic Cardiovascular Disease</u>		DUE TO (b) <u>Hypertension</u>		DUE TO (c) <u>Arterosclerosis</u>		> 10 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>337.5</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>M.D. 174 B K Street N.W. Wash. D.C.</u>		20f. (City or town) (County) (State) <u>Washington D.C.</u>	
21. I certify that I attended the deceased from <u>July 21, 1957</u> , to <u>July 21, 1957</u> , that I last saw the deceased alive on <u>July 21, 1957</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7/21/57</u>							
ACTUAL SIGNATURE <u>Habib Bacchus</u> M.D. <u>174 B K Street N.W. Wash. D.C.</u> DATE SIGNED <u>7/21/57</u>							
PHYSICIAN'S NAME (Type) <u>HABEEB BACCHUS</u> (Patient has been seen by Dr. W. Thompson previously) Suite 62. DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-24-57</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Hollings</u>		ADDRESS <u>Wash. D.C.</u>		24a. REC'D. BY REGISTRAR <u>111. 66</u>		24b. REGISTRAR'S SIGNATURE <u>Rosie Thompson</u>	
FRANCIS J. COLLINS-3821 14th. St. N.W.		DATE					

RECEIVED
MURRAY V. S.
2 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07574

CERTIFICATE OF DEATH

Reg. Dist. No.

07073
07673
223

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		b. STATE		
<i>Montgomery</i>				<i>Maryland</i>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
<i>Takoma Park</i>		<i>7 1/2 days</i>		<i>Takoma Park</i>		<i>7603 Central Ave.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<i>Washington San. + Hospital</i>								
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year
<i>Arthur</i>		<i>George</i>	<i>Parks</i>		<i>July</i>	<i>19</i>	<i>1957</i>	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years lost birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	
<i>Male</i>		<i>White</i>		<i>March 21, 1900</i>	<i>57 yrs.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
<i>Mechanic</i>				<i>Pennsylvania</i>		<i>U.S.A</i>		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
<i>Perry Parks</i>		<i>Mary Ann Louderstein</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO		17. INFORMANT		Address		
<i>No</i>				<i>Hospital Records</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c):]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Rocky Mountain Spotted Fever</i>				<i>12 days</i>		
104.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO						
(b) DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
19								
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, and that death occurred at _____, 19_____, and that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____. ADDRESS (Street, city or town, state)						DATE SIGNED		
ACTUAL SIGNATURE								
PHYSICIAN'S NAME (Type)								
RAYMOND O. WEST								
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)
<i>Scattered</i>		<i>July 22, 1957</i>		<i>Mt. Carmel Cemetery</i>		<i>Johnstown</i>		<i>Penna.</i>
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTERED SIGNATURE		
<i>J. Arthur Walters</i>		<i>254 Carroll St. N.W.</i>		<i>DATE</i>		<i>J. Wilson Dodd</i>		
				<i>7/20/57</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

07674

07575 CERTIFICATE OF DEATH

Reg. Dist. No. 7X3

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before, admissions, etc.) b. STATE	
Montgomery MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Takoma Park 2 Hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington San. of Hospital Takoma Park	
d. STREET ADDRESS 7108 Maple Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH First MIDDLE LAST MANNETTE BEACOCK	
5. SEX Female		Month Day Year 7 31 1957	
6. COLOR OR RACE White		8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9-27-20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife, Clerk, gift-stores.		9. AGE (In years lost birthday) 36 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Falston FOSTER	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS EVER ENLISTED IN U.S. ARMED FORCES? (Yes or no or unknown) No	
16. SOCIAL SECURITY NO. Yes.		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Acute Pulmonary Edema		INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fatty Liver		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 31, 1957, to July 31, 1957, that I last saw the deceased alive on July 31, 1957, and that death occurred at 4:50 PM from the causes and on the date stated above ACTUAL SIGNATURE Raymond O. West M.D.		ADDRESS (Street, city or town, state) Aug 1/57 DATE SIGNED	
22a. BURIAL, CREMATION BURIAL (Specify) Burial		22b. DATE THEREOF 8-5-1957	
22c. NAME OF CEMETERY OR CREMATORIUM WASH NATH CEM		22d. LOCATION (City, town, or county) SOUTHLAND (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE W.L. Chambers C		24a. ADDRESS Riverdale Rd. 24b. REG'D BY REGISTRAR 5801 - Cleveland Ave. DATE 1957	
		24b. REGISTRAR'S SIGNATURE J. Wilson Dadd	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MUG - 1957

REGISTRAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07576 CERTIFICATE OF DEATH

07675

Reg. Dist. No.

223

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL & DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 800 HAYWARD AVENUE				d. STREET ADDRESS 800 HAYWARD AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First MILDRED	Middle MARIE	Last PEAKE	4. DATE OF DEATH JULY 6 1957	Month JULY	Day 6	Year 1957
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12/6/94	9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME JOHN KOONTZ				14. MOTHER'S MAIDEN NAME TERESA DONOVAN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Donald F. Peake, 12, 332 Centerhill St. Wheaton, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				Pulmonary Failure Pulmonary tuberculosis bc severe debilitation		INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 5 years 2 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>arteriosclerotic heart disease</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month Hour a. m. p. m.	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 113 Carroll St NW	(County) Washington DC	(State) DC		
21. I certify that I attended the deceased from April 1957 to July 1957, that I last saw the deceased alive on July 3, 1957, and that death occurred at 3:00 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE James R Coleman MD				ADDRESS (Street, city or town, state) 113 Carroll St NW Washington 12 KC DATE SIGNED 7/6/57				
22a. BURIAL, CREMATION, REBURNAL (Specify) BURIAL		22b. DATE THEREOF 7/10/57		22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L CEMETERY		22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Warren G. Lumphrey,		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 7/10/57		24b. REGISTRAR'S SIGNATURE J. Nelson Dodd		

REGELY ED
BUREAU V. S.

JUL 11 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07676

(7690)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE				
Montgomery MARYLAND		Lebanon				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 192 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beirut				
3. NAME OF DECEASED (Type or print)		First Helen	Middle Vantrease			
		Last Phelps	4. DATE OF DEATH Month July Day 1, Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 23, 1897			
9. AGE (In years lost birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Tennessee			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas H. Vantrease				
14. MOTHER'S MAIDEN NAME Sarah McMillen		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				
16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) <i>Care of Breast Metastatic to Lungs Liver Bones</i>		INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from December 21, 1956, to July 1, 1957, that I last saw the deceased alive on July 1, 1957, and that death occurred at 1 A.M., from the causes and on the date stated above ADDRESS (Street, city or town, state)		ACTUAL SIGNATURE <i>Arthur J. Garceau</i>		DATE SIGNED 7/1/57		
PHYSICIAN'S NAME (Type) Arthur J. Garceau, M.D.		M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF July 1 1957	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	22d. LOCATION (City, town, or county) Silver Spring MD.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home		ADDRESS Wardell B. Thompson	24a. REC'D BY REGISTRAR DATE 7-8-57	24b. REGISTRAR'S SIGNATURE Benjamin Thompson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 2 & 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

BUREAU V. S.

JUL 10 1927

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

47677

(7691) CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 48 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION. The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
3. NAME OF DECEASED (Type or print) Ulric		4. DATE OF DEATH July 31, 1957	
First Ulric		Middle Bonnell	Last Phillips
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1912
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Government	9. AGE (In years last birthday) 45 yrs.
		11. BIRTHPLACE (State or foreign country) Michigan	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Ulrich Phillips		14. MOTHER'S MAIDEN NAME Lucie Mayo-Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Peritonitis + Empyema		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Leaking anastomosis of Esophagus + jejunum		DUE TO	
(c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acromegaly		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 13, 1957 to July 31, 1957 , that I last saw the deceased alive on July 31, 1957 , and that death occurred at 11:20 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Edward W. Moore M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 8/1/57		22b. DATE THEREOF 8/1/57	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Crematory
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		22d. LOCATION (City, town, or county) Suitland, Maryland	24a. REC'D BY REGISTRAR 8-1-57
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 prior to burial, cremation, or removal, and in any event within 72 hours after death. The signature on page 3 should be filed with the funeral director.

BUREAU Y.

WUG 5 100

DEPARTMENT OF
STATE

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18
(7692) CERTIFICATE OF DEATH

07678

Reg. Dist. No.

214

1. PLACE OF DEATH D. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) D. STATE	
MONTGOMERY MARYLAND		Md MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Rural Kensington		KENSINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
Kensington	10119 Crestwood Rd.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Male		B	PIERCE
6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov 17 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Retired		U.S. ARMY	Virginia
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
PIERCE		JANE ISABEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
No			IRMA P. FELLERS
Address		10119 Crestwood Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		, day	
Anoxia			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b)		Congestive Heart Failure 6 mos.	
DUE TO			
(c)		Atherosclerotic Heart disease 2-5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1957 to July 22, 1957, that I last saw the deceased alive on July 21, 1957, and that death occurred at 2:30 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE: SANFORD J RANDALL, M.D.		DATE SIGNED: 7/22/57	
PHYSICIAN'S NAME (Type): SANFORD J. RANDALL, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		7-26-57	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)	
Arlington Nat.		Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Neal Funeral Home 4812 Ga Avenue		24a. REC'D BY REGISTRAR	
		24b. REGISTRAR'S SIGNATURE	
		Lorraine Potter	

BUREAU V. S.

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
075 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07679
 773

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.		c. LENGTH OF STAY IN lb D O A		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hosp.		d. STREET ADDRESS 3010 Powder Mill Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Owen Ora Potter		First	Middle	Last	4. DATE OF DEATH July 25	Month	Day	Year			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 6, 1900	9. AGE (in years last birthday) 56	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Intelligence work		10b. KIND OF BUSINESS OR INDUSTRY Central Intelligence Agency		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME Francis Marion Potter		14. MOTHER'S MAIDEN NAME ? Shannon		Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WV 2, 4 Yrs.		17. INFORMANT Hospital Records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion										sudden	
4:00 A.M. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO _____ (c) _____ DUE TO _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 7-25-57						
EXAMINER'S NAME (Type) FRANK J. Broschart	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 7-28-57	22c. NAME OF CEMETERY OR CREMATORIAL Lees Crematory		22d. LOCATION (City, town, or county) Wash. D. C.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lees Son - Wash. D. C.		ADDRESS Lees Crematory		24a. REC'D BY REGISTRAR July 27, 1957		24b. REGISTRAR'S SIGNATURE J. W. Lees Son					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the date and hour when it was signed. If any portion of the certificate is to be changed, initial the change and sign below. If any portion of the certificate is to be destroyed, initial the destruction and sign below. This certificate is to be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill Pages 1 and 2 with the registrant's information.

RECEIVE

JUL 29 1957

BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07578

CERTIFICATE OF DEATH

07681
223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>MONTGOMERY</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>2 hours 7 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hospital</i>		d. STREET ADDRESS <i>7807 Flower Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Infant Boy</i>		First	Middle	Lost	4. DATE OF DEATH <i>Powell</i>	Month	Day	Year	
S SEX <i>Boy</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 21, 1957</i>	9. AGE (In years (lost birthday) yrs.) <i>1</i>	10. UNDER 1 YEAR IF UNDER 24 HRS Months <i>2</i>	Days <i>7</i>	Hours M.n. <i>7</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Ernest William Powell</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ann Alice Rick</i>		Address <i>TAKOMA PARK, D.C.</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <i>ERNEST Wm. POWELL JR. 7807 FLOWER AVE.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity.</i> DUE TO X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>July 21, 1957</i> , to <i>July 21, 1957</i> , that I last saw the deceased alive on <i>July 21, 1957</i> , and that death occurred at <i>11:15 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>M.D. 931 Berkeley Drive - 7/22/57</i>							
ACTUAL SIGNATURE <i>Ralph Stiller</i>		DATE SIGNED <i>7/22/57</i>							
PHYSICIAN'S NAME (Type) <i>Ralph Stiller</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 23/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>ARLINGTON NAT'L CEM. - ARLINGTON</i>		22d. LOCATION (City, town, or county) (State) <i>Va.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. N. Wilson, Jr.</i>		ADDRESS <i>254 Carroll St. N.W.</i>		24. DATE ISSUED BY REGISTRAR <i>JUL 24 1957</i>		25. REGISTRAR'S SIGNATURE <i>J. N. Wilson, Jr.</i>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page **I** may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

UREAU V.

11 L 25 1957

בְּגַיִוְתָּהּ כְּלֹמְדֵת אֶת־בְּנֵי־עֲמָקָם וְאֶת־בְּנֵי־בָּנָים
בְּגַיִוְתָּהּ כְּלֹמְדֵת אֶת־בְּנֵי־עֲמָקָם וְאֶת־בְּנֵי־בָּנָים

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07681

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D C b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home		d. STREET ADDRESS Clifton Terrace Apartments e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First EMMA	Middle C.	Last PRICE
4. DATE OF DEATH July 23	Month Year 1957	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1884
9. AGE (In years lrb. birthday yrs)		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Virginia		U.S.A.	
13. FATHER'S NAME James B. Price		14. MOTHER'S MAIDEN NAME Ida Coakley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or date of service]		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs Shirley Ashton, 4201 Massachusetts Avenue		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory and Cardiac failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 32 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 1, 1957</i> , to <i>Present</i> , that I last saw the deceased alive on <i>July 23, 1957</i> , and that death occurred at <i>9:58 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Donald O. Ekman, M.D. 5707 Wisconsin Avenue, Bethesda, Md. DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) DONALD O. EKMAN, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/26/57	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	22d. LOCATION (City, town, or county) Suitland Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Davids Son		1756 ADDRESS E.W. Washington, DC	24a. REC'D BY REGISTRAR 11 31 1957
			24b. REGISTRAR'S SIGNATURE Frances Polley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 31 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07682

216

(7694)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Ohio b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 91 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Pleasant	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS (no street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle Edward	Last Randolph	4. DATE OF DEATH Month July Day 11, Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 25, 1889	9. AGE (In years last birthday) 67 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME James Randolph			14. MOTHER'S MAIDEN NAME Martha Jordan		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 284-01-9790		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 204.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (as). (b) DUE TO (c) intracerebral bleeding. DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 year					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 11, 1957 to July 11, 1957 , that I last saw the deceased alive on July 11, 1957 , and that death occurred at 2:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 7/11/57					
ACTUAL SIGNATURE <i>David G. Nathan</i>		NAME (Type) David G. Nathan, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Shipped		22b. DATE THEREOF 7/12/57		22c. NAME OF CEMETERY OR CREMATORIUM Highland Cemetery	
22d. LOCATION (City, town, or village) Mt. Pleasant, Jefferson Co., Ohio.		22e. REG'D BY REGISTRAR JUL 1 1957		22f. REGISTRAR'S SIGNATURE Bessie Thompson	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>		ADDRESS Rockville, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07695

CERTIFICATE OF DEATH

117683

Reg. Dist. No.

216

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN lb

about 10 m.

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission)
a. STATE

Maryland

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

d. STREET ADDRESS

10705 Rock Run Rd

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

July

28

1957

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Dec. 1, 1891

9. AGE (In years
lost birthday)

65 yr

10. IF UNDER 1 YEAR

Months Days Hours Min.

100. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Carpenter

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Baltimore, Md

U.S.A.

13. FATHER'S NAME

John C. Reed

14. MOTHER'S MAIDEN NAME

Mary C. Creasman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes no or unknown)

No

16. SOCIAL SECURITY NO

239-03-6315

17. INFORMANT

Wife

Address

12th 14

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Ruptured Aneurysm, middle cerebral artery, left

INTERVAL BETWEEN

INSET AND DEATH

8 hours

DUE TO

Debilitating cerebral hemorrhage

{ Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

a hemiplegia (Rt) + A Phasia

DUE TO

Hypertension, atherosclerosis

(c)

MEDICAL CERTIFICATION

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour e. m.
p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/28, 1957, to 7/28, 1957, that I last saw the deceased
alive on 7/28, 1957, and that death occurred at 7:25 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

M.D. Bethesda, Md 7/28/57

NAME (Type)

22a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Sp. Cr.)

Burial Aug. 1, 1957

22c. NAME OF CEMETERY OR BURIALARY

Hart Lincoln

22d. LOCATION (City/town, or county)

Clarendon, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

J. Stan Lee & Sons Washington D.C.

ADDRESS

24a. REC'D BY REGISTRAR

DATE

Jul 31 '57

O. Legion Hospital

24b. REGISTRAR'S SIGNATURE

DATE

Jul 31 '57

O. Legion Hospital

RECEIVED
BUREAU V. S.

UL 31 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07684
07893 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 215

1 DEPUTY MEDICAL EXAMINER: This certificate shall be executed by the certifying medical examiner, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Hoboken			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hoboken		d. STREET ADDRESS 157 14th St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edward		First (nnn)	Middle REEVES	Last	4. DATE OF DEATH Month July	Day 9	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10 July 1935	9. AGE (In years to last birthday) 21 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward REEVES				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Currently		16. SOCIAL SECURITY NO.		17. INFORMANT Address Wife, Mrs. Joan Reeves (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hematoma, left DUE TO Conditions, if any, which gave rise to immediate cause (b) Skull fracture, linear, left parieto occipital area 1 week DUE TO cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRINCIPAL CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Lost Control of Motor-Bike striking tree					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 7/2 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street,		20f. (City or town) (County) (State) Bermuda, British West Indies	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-10-57	
EXAMINER'S NAME (Type) Frank J. Broschart, MD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-15-57		22c. NAME OF CEMETERY OR CREMATORIAL Nat'l Cemetery,		22d. LOCATION (City, town, or county) (State) Farmingdale, Long Is. and, New York	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dorothy Pumphrey</i> R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, MD		ADDRESS 7-9-57		24a. REC'D BY REGISTRAR 7-9-57		24b. REGISTRAR'S SIGNATURE <i>Mary C. Russell</i>	

RECEIVED
BUREAU V. S.

JUL 16 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07685

07697

CERTIFICATE OF DEATH

Reg. Dist. No. 16

PLACE OF DEATH
o COUNTY

Montgomery

MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o STATE Alabama
b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN lb

27 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Birmingham

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS

4909 Avenue "O"

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
JulyDay
13, 1957
Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9. AGE (In years
lost birthday)

28 yrs

IF UNDER 1 YEAR

IF UNDER 24 HRS

Months

Days

Hours

Min.

Female

White

November 2, 1928

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Alabama

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Luther J. Hornsby

14. MOTHER'S MAIDEN NAME

Irene Thornton

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no or unknown)

No

16. SOCIAL SECURITY NO.

420-34-1546

17. INFORMANT The Medical Record Address

The Clinical Center, Bethesda 14, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a)

421.4

DUE TO

Conditions if any, which
gave rise to immediate
cause (a), stating the under-
lying cause (b)

DUE TO

(b) CHF, shock, electrolyte abnormality

(c) P.C. clausura of 493D & Pul. Valvulotomy

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from June 16, 1957, to July 13, 1957, that I last saw the deceased
alive on July 13, 1957, and that death occurred at 6:45 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

CARLOS R. LOMBARDO, M. D.

The Clinical Center

7/14/57

National Institutes of Health
Bethesda 14, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THE EOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

Trans Burial 7-18-57

Union Hill

Arab

Alabama

23. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey 7559 ADDRESS Memphis
Wisc Ave Beth Md DATE 7-16-57 REG'D BY REGISTRAR
Bessie M. Thornton

May 2

JUL 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07579

CERTIFICATE OF DEATH

07686

773

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Montgomery</i> MARYLAND		b. STATE <i>Md.</i> b. COUNTY <i>Towson</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Toloma Park</i>		c. LENGTH OF STAY IN 1b <i>10 minutes</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanatorium Hosp.</i>		d. STREET ADDRESS <i>149 Fleetwood Terrace</i>	
3. NAME OF DECEASED (Type or print) <i>Emilia</i>		First <i>Lilija</i>	Middle <i>Russis</i>
3. NAME OF DECEASED (Type or print) <i>Emilia</i>		Last <i>Russis</i>	4. DATE OF DEATH <i>7-7-1957</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>196-9-88</i>		9. AGE (In years (last birthday) Yrs. <i>64</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Latvia</i>	
12. CITIZEN OF WHAT COUNTRY <i>Latvia</i>		13. FATHER'S NAME <i>Martin Kreitels</i>	
14. MOTHER'S MAIDEN NAME <i>Christina Kuznetzoff</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes/no or unknown) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Washington Sanatorium Hospital Park</i>	
18. CAUSE OF DEATH [Enter only one cause per line; for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>463 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>EMBOLIC THROMBOLYSIS OF PULMONARY ARTERY</i> <i>THROMBOPHLEBITIS OF RT. LEG</i>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>462 X</i>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D.</i>		20f. (City or town) (County) (State) <i>Silver Spring, Maryland</i>	
21. I certify that I attended the deceased from <i>June 28, 1957</i> to <i>July 7, 1957</i> , that I last saw the deceased alive on <i>July 7, 1957</i> , and that death occurred at <i>5:25 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Silver Spring, Maryland</i>	
ACTUAL SIGNATURE <i>Emilia Russis</i>		DATE SIGNED <i>July 9, 1957</i>	
PHYSICIAN'S NAME (Type) <i>EINC MAG</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>7/10/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek Cemetery</i>	
22d. LOCATION (City, town or county) <i>Washington, D. C.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>He S. H. Hinckle, 2901 14th NW DC</i>		24a. REC'D BY REGISTRAR <i>JUL 9 1957</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>J. Wilson</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

JUL 9 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 0769 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

117687
216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <u>Maryland</u>	b. COUNTY <u>Montgomery</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	d. STREET ADDRESS <u>6313 Winston Drive</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6313 Winston Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN BRUCE RUSSELL</u>	First <u>JOHN</u>	Middle <u>BRUCE</u>	Last <u>RUSSELL</u>
4. DATE OF DEATH <u>July 14, 1957</u>	Month <u>July</u>	Day <u>14</u>	Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2/18/33</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>College</u>	11. BIRTHPLACE (State or foreign country) <u>Florida</u>	9. AGE (In years from birthday) <u>24 yrs</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>	13. FATHER'S NAME <u>Frank R. Russell</u>	14. MOTHER'S MAIDEN NAME <u>Violet Bruce</u>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>
	16. SOCIAL SECURITY NO <u>217-32-2597</u>	17. INFORMANT <u>Frank Russell</u>	Address <u>Same as #2</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 974X Conditions if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>DUE TO</u> <u>Due to Hanging</u> (c) -			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Hung self by bath towel in bath room</u>		
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <u>7/14/57</u>
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/16/57</u>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Columbia Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>	24a. REC'D BY REGISTRAR <u>7-16-57</u>	24b. REGISTRAR'S SIGNATURE <u>Broschart</u>	

REGATIVE

JUL 18 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07699

CERTIFICATE OF DEATH

07658

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE A. C.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 38 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASH D C 41x				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 4000 mass ave NW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First MARIE	Middle Herrmann	Last Salsman	4. DATE OF DEATH July 26 1957	Month July	Day 26	Year 1957
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> JUNE 14 1896	9. AGE (In years last birthday) 61 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0	13. MIN
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WISCONSIN		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Otto J. Herrmann		14. MOTHER'S MAIDEN NAME Bertha Schmidt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Col. John Salsman		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first Gangrene of lower extremities		DUE TO b) Clot in abdominal aorta.		INTERVAL BETWEEN ONSET AND DEATH 10 days				
		DUE TO c) Arrhythmia, Fibillitation & generalized arteriosclerosis		3 weeks				
				5 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 154X				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 19						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from June 18 1957 to July 26 1957 , that I last saw the deceased alive on July 26 1957 , and that death occurred at 10:15 AM , from the causes and on the date stated above. ACTUAL SIGNATURE John A. Thomas		M.D. 4301 47th st NW, Wash D.C.		ADDRESS (Street, city or town, state) DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-24-57		22c. NAME OF CEMETERY OR CREMATORIUM ABINGTON NATIONAL		22d. LOCATION (City, town, or county) ABINGTON Va		
23. FUNERAL DIRECTOR'S SIGNATURE Dorothy Sanderson 202-1756 Peppermint Ave NW Washington DC		ADDRESS Washington DC		24a. REC'D BY REGISTRAR 7-29-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JULY 11 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07700

CERTIFICATE OF DEATH

Reg. Dist. No. 07689

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE New Hampshire b. COUNTY Merrimack	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) 11 mos. 27 days		c. LENGTH OF STAY IN lb Penacook	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS 33 Water Street	
3. NAME OF DECEASED (Type or print) Edward Matthew SAMPSON		4. DATE OF DEATH July 4 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH November 21, 1921
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		9. AGE (In years last birthday) 35 yrs	
10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) New Hampshire	
13. FATHER'S NAME Alma SAMPSON		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Yes		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT (Wife) Mrs. Sophia C. SAMPSON (Same as #2)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Lymphosarcoma INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 31, 1956, to July 4, 1957, that I last saw the deceased alive on July 3, 1957, and that death occurred at 5:34 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Gerald I. Shugoll PHYSICIAN'S NAME (Type) Gerald I. Shugoll, LT, MC, USN ADDRESS U.S. Naval Hospital, Bethesda, Md. 7-5-57		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF -07-57	
22c. NAME OF CEMETERY OR CREMATORIUM BLOSSOM Hill Cemetery		22d. LOCATION (City, town, or county) (State) Concord New Hampshire	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 7-5-57	
ADDRESS		24b. REGISTRAR'S SIGNATURE Mary E. Farrell	

BUREAU V. S.

JUL 1 1971

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07690

Reg. Dist. No. 246

1 PLACE OF DEATH a. COUNTY Montgomery			MARYLAND			2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c LENGTH OF STAY IN lb 2 weeks			d. STATE Dist. of Columbia					
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp.						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Washington					
3. NAME OF DECEASED (Type or print) Violet			First Minion ette	Middle Sav age	Last	4. DATE OF DEATH July 4,	Month	Day	Year		
5. SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH April 9, 1889			9 AGE (in years last birthday) 68 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS				
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary			10b KIND OF BUSINESS OR INDUSTRY Am. Red Cross			11. BIRTHPLACE (State or foreign country) Jamaica, Brit. West Indies			12 CITIZEN OF WHAT COUNTRY? B.W.I.		
13. FATHER'S NAME Edward A. Savage			14 MOTHER'S MAIDEN NAME Mary Livina Surridge			Address 5416 20th Ave. Hyattsville, Md.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.			17. INFORMANT Harold W. Savage, 5416 20th Ave. Hyattsville, Md.			INTERVAL BETWEEN ONSET AND DEATH 1 wks.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			Hemiplegia, right, acute severe.						INTERVAL BETWEEN ONSET AND DEATH 4 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1) Previous hemiplegia 2 yrs ago. 2) Renal failure.									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 2 - it x								
20c TIME OF INJURY Hour a. m. p. m.	Month 19	Year	20d INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)						
21. I certify that I attended the deceased from 1949, to July 4, 1957, that I last saw the deceased alive on July 4, 1957, and that death occurred at 10:00 PM, from the causes and on the date stated above.											
ACTUAL SIGNATURE Stewart Glass	M.D.			ADDRESS (Street, city or town, state) 3921 Ingomar St N.E. 20551							
PHYSICIAN'S NAME (Type) Stewart Glass	DATE SIGNED										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-8-57	22c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cemetery	22d. LOCATION (City, town, or county) Washington, D. C.			(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey Bethesda, Md.			ADDRESS	24a. REC'D BY REGISTRAR 7-10-57			24b. REGISTRAR'S SIGNATURE Bessie Thompson				

BUREAU V.

JUL 12 1957

REGELIV FED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07691

07702

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)	
Montgomery				a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 15 days		Virginia Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital		e. STREET ADDRESS 4731 North 34th Street		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Maggie		First	Middle	Last	4. DATE OF DEATH July 5 19 57
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 3/11/68	9. AGE (In years last birthday) 88 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) XXXXXX PENNSYLVANIA	
13. FATHER'S NAME Samuel Schuler		14. MOTHER'S MAIDEN NAME Catherine Roeder		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Hospital Record	
No					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 7 days			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5721 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Infantile) Obstruction Acute diverticulitis 15 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ 6/25/57 to _____ 7/5/57 that I last saw the deceased alive on _____ 7/5/57, and that death occurred at 2:50 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) T. W. B. M. C. H. L. I. O. N		ADDRESS (Street, city or town, state) DATE SIGNED Sandy Spring, Md. 7/5/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 7/9/57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM Chas. Evans Memorial Cemetery	
				22d. LOCATION (City, town, or county) Reading, Pennsylvania (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Lumphrey 8434 1/2 Ave		ADDRESS Silver Spring Md.		24a. REC'D BY REGISTRAR DATE 7/8/57	
				24b. REGISTRAR'S SIGNATURE George B. Lamb	

TRÉAU V.

UL 1957

KLEGELIV ELC

07992

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Montgomery</i>		a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN lb <i>7 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>8708 Green Rd</i>		d. STREET ADDRESS <i>8708 Green Rd</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Joseph Bradford Shaw</i>		First	Middle
4. DATE OF DEATH <i>July 1, 1957</i>		Last	
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>5-13-1894</i>		9. AGE (in years, but birthday) <i>73 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired School Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Shaw</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yr. no. or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>218-30-1826</i>	
17. INFORMANT <i>Gene Hoeltje - Sonne # 2</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Coronary occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <i>(State)</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED <i>7-1-57</i>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>7/5/57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>FT. LINCOLN CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>PRINCE GEORGE COUNTY, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Darlene E. Humphrey</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
24a. REC'D BY REGISTRAR DATE <i>7/5/57</i>		24b. REGISTRAR'S SIGNATURE <i>James Potter</i>	

1 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 4 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation.

BUREAU V. S.

JUL 6 19

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07580

CERTIFICATE OF DEATH

07693

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		b. COUNTY		
Montgomery				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Takoma Park		33 hrs.		District of Columbia				
Washington Sanitarium + Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
				209 - 15 th Street N.E.				
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH		Month	Day	Year
George		Frank	Sheldon	July 30, 1957				
5. SEX		6. COLOR OF FACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
Male		White		1 - 24 - 79		78	0	0 0 0 0
10a. USUAL OCCUPATION (Give kind of work done During most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Secretary				Civil Serv. Adm.		Edgewood, Md.		Malvern, Iowa America
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Edward Sheldon		Mattie Hobbs						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No or Unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		—		Hospital Records.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		Myocardial infarction				60 hours		
DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Coronary arteriosclerosis				5 years.		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
Month, Day, Year 19								
21. I certify that I attended the deceased from 21 July 1952, to 30 July 1952, that I last saw the deceased alive on 27 July 1952, and that death occurred at 6:40 AM, from the causes and on the date stated above.								ADDRESS (Street, city or town, state)
								DATE SIGNED
ACTUAL SIGNATURE		SEARCH T. KIMBLE		M.D.		929 Pershing Drive, Silver Spring		July 30, 1957
PHYSICIAN'S NAME (Type)		SEARCH T. KIMBLE						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY, OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)
CREMATION		JULY 31, 1957.		CEDAR HILL CREMATORIAL		PENNA AVE E		DC MD
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
J. Arthur Matthews		254 Carroll Street N.W. Takoma Park, Md.		DATE 7/31/57		J. Nelson Dodd		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3/30/57 11⁰⁰ am.
RECEIVED
1957 phone order from Dr. Timbles office
that Coroner released body -
-75 Benevian

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07694

0758 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

223

PROPERTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN lb 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 241 PARK AVENUE				d. STREET ADDRESS 241 PARK AVENUE				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) JOSEPH BERNARD SIMPSON, SR.		First	Middle	Last	4. DATE OF DEATH JULY 1 19 57	Month	Day	Year
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1879	9. AGE (in years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT (Retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) BURKE, VIRGINIA		
12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME JAMES HENRY SIMPSON				14. MOTHER'S MAIDEN NAME MARY ELLEN RATCLIFFE SKINNER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. YES		17. INFORMANT Miss Vivian V. Simpson, 241 Park Ave.		Address Takoma Park		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		DATE SIGNED <u>7-1-57</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/5/57		22c. NAME OF CEMETERY OR CREMATORIUM FAIRVIEW CEMETERY		22d. LOCATION (City, town, or county) CULPEPPER, VIRGINIA (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren E. Lumpkey</u>		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR <u>J. H. L. 5 - 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. L. 5 - 1957</u>		

BUREAU V. S

UL A 257

REGELYED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 (which should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar) prior to burial, cremation, or removal, and in any event within 72 hours after death.

VIS A TS (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07704

Item 5, Form 3100, 3/25/55

CERTIFICATE OF DEATH

07695

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		b. STATE		
Montgomery Co.				Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1B		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
Bethesda		5 hrs		Bethesda		6904 STRATHMORE ST.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Suburban								
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Howard William Sinclair					July	26	1957	
S. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)			10. IF UNDER 1 YEAR, IF UNDER 24 HRS.
M		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 24, 1893	64 yrs.	Months 9	Days 2	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?
Personnel Mng			Biolog Lab		Main			US
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME					
William Sinclair			Ada BARROWS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address Ad - Bethesda	
No			None		William R. Sinclair - 9807 Holmwood			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			7 hours					
Coronary Artery Thrombosis								
DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.								
(b) Coronary Arteriosclerosis								
DUE TO								
(c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 26, 1957, to July 26, 1957, that I last saw the deceased alive on July 26, 1957, and that death occurred at 6:05 P.M., from the causes and on the date stated above.			ADDRESS (Street, city or town, state) M.D. 4630 Montg. Ave., Bethesda, Md. DATE SIGNED 7/26/57					
ACTUAL SIGNATURE								
PHYSICIAN'S NAME (Type)			Robert N. Coale, M.d.					
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town or county) (State)	
Cremation			7/27/1957		Cedar Hill		Prince Georges Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS		24a. REC'D BY REGISTRAR DATE 7-27-57		24b. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.							Bessie Thompson	

REGELIVEL
BUREAU V. S.

JUL 20 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07696.

07705

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 1 hr. 45 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 2613 S. 8th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	Last SMIDDY	4. DATE OF DEATH 4 July 1957	Month July	Day 4	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4 July 1957	9. AGE (In years lost birthday) yrs. 1	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS Days 1	Hours 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Patrick SMIDDY		14. MOTHER'S MAIDEN NAME Cynthia Gwendolin HALL					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Joseph P. SMIDDY (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		In maturity - Prematurity		INTERVAL BETWEEN ONSEP AND DEATH 1 hr 45 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 4 July 1957, to 4 July 1957, that I last saw the deceased alive on 4 July 1957, and that death occurred at 8:20P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE George J. A. Magnant	M.D. U.S. Naval Hospital, Bethesda, Md. 7-6-57						DATE SIGNED
PHYSICIAN'S NAME (Type) George J.A. Magnant, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION BURIAL	22b. DATE THEREOF 7-11-57	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey Funeral Home,	ADDRESS 7557 Wisc.Ave.	24a. REC'D BY REGISTRAR 7-5-57		24b. REGISTRAR'S SIGNATURE Mary L. Russell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 8 1937

RECEIVED

FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. If any delay is necessary, write the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07697
Reg. Dist. No. 916

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE	
<i>Montgomery</i>		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 8 yrs	
<i>Chevy Chase</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<i>4007 Homestead St</i>		<i>4007 Homestead St</i>	
e. NAME OF DECEASED (Type or print)		f. DATE OF DEATH	
<i>Jane Elizabeth Smith</i>		July 28 1957	
g. SEX		h. COLOR OR RACE	
Female		White	
i. MARRIED		j. NEVER MARRIED	
WIDOWED		DIVORCED	
k. DATE OF BIRTH		l. AGE (In years at birthday)	
6-28-1860		97 yrs.	
m. USUAL OCCUPATION (Type kind of work done during last of working life, even if retired)		n. KIND OF BUSINESS OR INDUSTRY	
<i>Housewife</i>			
o. BIRTHPLACE (State or foreign country)		p. IF UNDER 1 YEAR	
<i>Va.</i>		IF UNDER 24 HRS	
q. CITIZEN OF WHAT COUNTRY?		r. Months Days Hours Min	
<i>USA</i>			
s. FATHER'S NAME		t. MOTHER'S MAIDEN NAME	
<i>Fredrich J. Geisendaffer</i>		<i>Mary Louise Mcutherford</i>	
u. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown)		v. SOCIAL SECURITY NO	
No		165-10-1234	
w. INFORMANT		x. INTERVAL BETWEEN ONSET AND DEATH	
Fred A. Smith		2 days	
y. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		z. Acute Cardiac Failure	
Sudden		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b)	
		DUE TO	
		(c)	
aa. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		bb. WAS AN AUTOPSY PERFORMED?	
cc. 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		dd. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part f or Part ff of item 18.)	
ee. 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		ff. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		gg. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		hh. 20f. (City or town) (County) (State)	
ii. 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		jj. 22. MEDICAL CERTIFICATION ACTUAL SIGNATURE <i>Frank J. Broschart</i>	
kk. EXAMINER'S NAME (Type)		ll. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ll. 22a. BURIAL CREMATION, DATE THEREOF REMOVAL (Specify)		mm. 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
Burial 7-31-57		Presbyterian Cemetery Washington, D.C.	
nn. 23. FUNERAL DIRECTOR'S SIGNATURE		oo. 22d. LOCATION (City, town, or county) (State)	
<i>Joseph Brown, Jr. Son Washington, D.C.</i>		pp. 24a. REC'D BY REGISTRAR DATE 7-30-57	
		qq. 24b. REGISTRAR'S SIGNATURE Date 7-30-57	

BUREAU V. S.

MUG I 1057

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07582

CERTIFICATE OF DEATH

07698
223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) b. STATE		Md., Montgomery			
Montgomery				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY			
Takoma Park		6 Days		Takoma Park					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. LENGTH OF STAY IN lb		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Washington San + Hospital				7411 Hancock Ave					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Keitha Geraldine Smith					July	22	1957		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. CITIZEN OF WHAT COUNTRY?
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	June 24, 1883	74 yrs.				USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		on home		Canada					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT	
Alexander Campear		Sarah Ann Herrington		NO		110-26-2531		Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Infarct, rt. cerebral hemisphere		INTERVAL BETWEEN ONSET AND DEATH few days			
		DUE TO		Thrombosis, rt. middle cerebral artery					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)									
18 IX									
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
Cystotomy for papillary carcinoma, urinary bladder, post op.		YES							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 14, 1957, to July 22, 1957, that I last saw the deceased alive on July 22, 1957, and that death occurred at 12:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		M.D.		DATE SIGNED			
ACTUAL SIGNATURE Raymond O. West		1600 Carroll Ave				July 22, 1957			
PHYSICIAN'S NAME (Type)		Takoma Park							
22a. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)			
Burial		July 26, 1957		Rock Creek Cemetery		Washington, D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D. BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE			
Warren C. Humphrey		Silver Spring, Md.		JUL 25 1957		J. William Bell			

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

JUL 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07699

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 hrs.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Mary L. Spreckelmyer		First Mary	Middle L.	Last Spreckelmyer	4. DATE OF DEATH 7 18 1957	Month 7	Day 18	Year 1957	5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/1900	9. AGE (In years last birthday) 57 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (State or foreign country) District of Columbia	13. CITIZEN OF WHAT COUNTRY? U.S.A.
14. FATHER'S NAME Patrick S. Walshe		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes	17. INFORMANT John Spreckelmyer	Address 3715 Ch.Ch. Lake Dr., Ch. Ch., Md.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hypertensive Art. & Dis. of heart DUE TO (c) CARDIOVASCULAR disease - year						INTERVAL BETWEEN ONSET AND DEATH 10 hours											
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from July 17, 1957 to July 17, 1957 that I last saw the deceased alive on July 17, 1957 , and that death occurred at 2 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE John Howell M.D.				ADDRESS (Street, city or town, state) 5401 Western Ave N.W.		DATE SIGNED											
22a. BURIAL, CREMATION, REMOVAL (S) Burial		22b. DATE THEREOF July 20, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven		22d. LOCATION (City, town, or county) Montgomery County, Maryland											
23. FUNERAL DIRECTOR'S SIGNATURE William L. Howell		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 7-20-57		24b. REGISTRAR'S SIGNATURE 7-20-57											

SPITAL ATTENDANT: The law requires that the death certificate be executed within 24 hours after death
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 22 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07700

07583

CERTIFICATE OF DEATH

Reg. Dist. No.

223

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE D.C.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN IB 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN + HOSP.		d. STREET ADDRESS 5104 14th St. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOSEPH	Middle BENJAMIN	Last STEIN	4. DATE OF DEATH JULY 14 1957	Month Day Year		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 58 Jan 1889	9. AGE (In years last birthday) 68 yrs.	10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY		10b. KIND OF BUSINESS OR INDUSTRY LAW.		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME JACOB STEIN		14. MOTHER'S MAIDEN NAME NICHE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT OREN STEIN, SON		Address 5104 14th St. W.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) METASTATIC CARCINOMA		INTERVAL BETWEEN ONSET AND DEATH 1mo.	
DUE TO 163X		DUE TO CARCINOMA LUNG		DUE TO (b) CARCINOMA LUNG		3mo	
(c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7-1 , 1957, to 7-14 , 1957, that I last saw the deceased alive on 7-14 , 1957, and that death occurred at 415 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) M.D. 1801 K ST. N.W. WASH. D.C.		DATE SIGNED 7-14-57	
ACTUAL SIGNATURE <i>James C. Mandes</i>							
PHYSICIAN'S NAME (Type) JAMES C. MANDES							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/15-1957		22c. NAME OF CEMETERY OR CREMATORIUM Adas Israel		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Golding Funeral Home</i>		ADDRESS 4217 9th St. N.W.		24e. REC'D BY REGISTRAR DATE 7/16/57		24f. REGISTRAR'S SIGNATURE <i>Wilson Kroll</i>	

JUL 17 1997

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 F 12-63-10
07708

07708

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	b. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN lb 8 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	d. STREET ADDRESS 8510 Salem Way
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8510 Salem Way	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Pearl	First mmi	Middle Strickland	Last 4. DATE OF DEATH July 22
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1911
9. AGE (In years last birthday) 46 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary H.O.L.C. payroll (Govt.)	10b. KIND OF BUSINESS OR INDUSTRY Missouri	11. BIRTHPLACE (State or foreign country) U. S. A.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Henry W. Strickland	14. MOTHER'S MAIDEN NAME Mabel Powell	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Henry Strickland	Ojus, Florida
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO METASTASES, LIVER, PERITONIUM 4 Mon. (c)			
INTERVAL BETWEEN ONSET AND DEATH 9 mon.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:50 AM July 22, 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 7 , 1957, to JULY 22 , 1957, that I last saw the deceased alive on JULY 21 , 1957, and that death occurred at 5:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Robert G. Angle	M.D.	5009 Del Ray Ave., Bethesda, Md.	7/27/57
PHYSICIAN'S NAME (Type) Robert G. Angle			
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	22b. DATE THEREOF 7/24/57	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Mausoleum	22d. LOCATION (City, town, or county) (State) Prince George's Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Lumpkin	ADDRESS Silver Spring, Md.	24a. REC'D BY REGISTRAR 7-24-57	24b. REGISTRAR'S SIGNATURE Bennie M. Thompson

FAU V. S

JUL 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07702
223

07584

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE Maryland OHIO MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c LENGTH OF STAY IN 1b 7 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CLEVELAND	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d STREET ADDRESS 3516 East 106th Street X 7060 Forest Glen Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Anna	Middle D.	Last Strodtbeck	4. DATE OF DEATH July 3 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-74	9. AGE (In years last birthday) 02 yrs.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		10c. BIRTHPLACE (State or foreign country) Michigan
13 FATHER'S NAME James Prine		14 MOTHER'S MAIDEN NAME Margaret Daykin		12. CITIZEN OF WHAT COUNTRY? American
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO	17. INFORMANT Hospital Records	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 11. / DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Acute gastritis		INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 20, 1957</u> , to <u>July 3, 1957</u> , that I last saw the deceased alive on <u>July 2, 1957</u> , and that death occurred at <u>1:35 AM</u> , from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>Bennet A. Porter, Jr., M.D.</i>	ADDRESS (Street, city or town, state) <i>9301 Colesville Rd., Silver Spring, Md.</i>			DATE SIGNED <i>July 3, 1957</i>
NAME (Type) BENNET A. PORTER, JR.				
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 7/3/57	22b. DATE THEREOF 55	22c. NAME OF CEMETERY OR CREMATORIUM ACACIA PARK CEMETERY	22d LOCATION (City, town, or county) CLEVELAND, OHIO (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Turner E. Lumpkin 8454 Galtine May</i>	ADDRESS 55	24a. RECD BY REGISTRAR DATE JUL 5 - 1957	24b. REGISTRAR'S SIGNATURE <i>J. William Doherty</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 & 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

GEREAU V. S.

JUL 8 1957

REGEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07799

CERTIFICATE OF DEATH

07703
2,6

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 113 days				
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5401 Farragut Street				
f. STREET ADDRESS Hyattsville, Maryland		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ruth Marie Swann		4. DATE OF DEATH Month July Day 22 , Year 1957				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 16, 1905			
9. AGE (In years from birthday) 51 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Health Agency	11. BIRTHPLACE (State or foreign country) Indiana			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles W. Goss				
14. MOTHER'S MAIDEN NAME Grace G. Stephenson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				
16. SOCIAL SECURITY NO. 220-32-6399		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) METASTATIC CARCINOMA OF RT BREAST DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 40 DAYS				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CORONARY ARTERIOSCLEROSIS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Arlington	(County) Arlington Co.	(State) MD
21. I certify that I attended the deceased from March 31, 1957 to July 22, 1957 that I last saw the deceased alive on July 22, 1957 , and that death occurred at 12:45 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Richard K. Shaw M.D.						
ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland						
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/57	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National	22d. LOCATION (City, town, or county) Arlington Va		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		ADDRESS Hyattsville, Maryland	24a. REC'D BY REGISTRAR JUL 26 1957	24b. REGISTRAR'S SIGNATURE Bessie Thompson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EAU V. E

JUL 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07704
Reg. Dist. No. 217

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07710 CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery					MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney					c. LENGTH OF STAY IN 1b 16 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring				
3. NAME OF DECEASED (Type or print)		First William	Middle John	Last Thomas	4. DATE OF DEATH July 24 1957		Month July	Day 24	Year 1957
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6/28/84	9. AGE (In years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Field Officer in Sandy Spring Bank					10b. KIND OF BUSINESS OR INDUSTRY Maryland				
13. FATHER'S NAME John Thomas					14. MOTHER'S MAIDEN NAME Catherine Vickers				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown					16. SOCIAL SECURITY NO. 217-14-7255				
17. INFORMANT Hospital Record					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Coronary Thrombosis									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400.1									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Colonary Atherosclerosis									
DUE TO (c) years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Precious myocardial infarctions with cardiac dilatation									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 6/17 , 1957, to 7/24 , 1957, that I last saw the deceased alive on 7/24 , 1957, and that death occurred at 3:15 P.M. from the causes and on the date stated above									
ADDRESS (Street, city or town, state) Sandy Spring									
DATE SIGNED 7/25/57									
MEDICAL CERTIFICATION J. W. Bird, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 27		22c. NAME OF CEMETERY OR CREMATORIUM Friends Cemt.		22d. LOCATION (City, town, or county) Sandy Spring		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Royce Barber									
ADDRESS Laytonsville, Md.					24a. REC'D BY REGISTRAR 7-26-57				
					24b. REGISTRAR'S SIGNATURE Barbara B. Lander				

RECEIVED

BUREAU V.

JUL 31 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07711

CERTIFICATE OF DEATH

07705

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oney</i>		c. LENGTH OF STAY IN 1b <i>6 Years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Xa Unknown</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARMS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Sarah</i>	Middle <i></i>	Last <i>Thorpe</i>	4. DATE OF DEATH <i>July 22 1957</i>	Month Day Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb-21-1866</i>	9. AGE (In years 1st birthday) <i>91 yrs</i>	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Dixon-Illinois</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>Willis Russell</i>		14. MOTHER'S MAIDEN NAME <i>Eliza Simpson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Med. rec'd d. Brooke Grove Foundation</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Ren. art. Sclerosis, debilit</i> (c) <i>+Cachexia</i>				<i>15 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>433.1</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
19					
21. I certify that I attended the deceased from <i>March</i> , 1957, to <i>21 July</i> , 1957, that I last saw the deceased alive on <i>20 July</i> , 19 <i>5?</i> , and that death occurred at <i>10:44 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Alney Md</i>					
ACTUAL SIGNATURE <i>John Bosley Ziegler M.D.</i>	DATE SIGNED <i>23 July 57</i>				
PHYSICIAN'S NAME (Type) <i>JOHN BOSLEY ZIEGLER</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>July 25</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Laytonsville, Meth.</i>	22d. LOCATION (City, town, or county) <i>Laytonsville, Md.</i>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Doyne Barber</i>	ADDRESS <i>Laytonsville, Md.</i>	24a. REC'D BY REGISTRAR <i>✓ 26 57</i>	24b. REGISTRAR'S SIGNATURE <i>Lorraine B. Lawler</i>		

1 ATTENDING PHYSICIAN: The law requires that the doctor or attending physician be retained by the hospital or attending physician.

2 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon papers. Pages 3 & 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 31 1957

BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07712

CERTIFICATE OF DEATH

07706

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Hockville</i>		c. LENGTH OF STAY IN 16 RURAL and give nearest town) <i>30 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Hockville</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>11105 Old Georgetown Road</i>		d. STREET ADDRESS <i>11105 Old Georgetown Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>George</i>		First	Middle	Lost	4. DATE OF DEATH <i>July 11</i>	Month	Day	Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>6/4/1904</i>	9. AGE (In years lost birthday) <i>53 yrs.</i>	IF UNDER 1 YEAR Months <i>1</i>	IF UNDER 24 HRS Days <i>7</i>	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Trainman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>D. C. Transit</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>		
13. FATHER'S NAME <i>Fredrick D. Tillman</i>		14. MOTHER'S MAIDEN NAME <i>Maude G. Fields</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>578-10-5375</i>		17. INFORMANT <i>Margaret W. Tillman, Above #2</i>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary occlusion</i>						<i>1 day.</i>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. <i>None</i>		(b) DUE TO <i>Coronary arteriosclerosis, hypertension</i>				<i>5 years</i>		
(c) DUE TO <i>(1 previous occlusion Nov. 1956)</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>						
20c. TIME OF INJURY Month Day Year Hour o.m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) <i>None</i>		(County) <i>None</i> (State) <i>None</i>
21. I certify that I attended the deceased from <i>July 10, 1957</i> , to <i>July 11, 1957</i> , that I last saw the deceased alive on <i>July 10, 1957</i> , and that death occurred at <i>5809</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Georgetown, Md.</i>		DATE SIGNED <i>July 11/57</i>
ACTUAL SIGNATURE <i>Jeff. Tillman</i>								
PHYSICIAN'S NAME (Type) <i>J. M. A. Linthicum</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/13/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Mary's</i>		22d. LOCATION (City, town, or county) <i>Rockville, Maryland</i>		(State) <i>None</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i>		ADDRESS <i>Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR <i>JUL 15 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Karen L. Tracy</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S

May 15 1957

REGELIV

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08739

07713

CERTIFICATE OF DEATH

Reg. Dist. No.

216

PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 505 W. Montgomery Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Adas		First Middle Last		4. DATE OF DEATH July 31 1957		Month Day Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 24, 1870	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia		9. AGE (In years last birthday) 86 yrs	
13. FATHER'S NAME John B. Pumphrey		14. MOTHER'S MAIDEN NAME Annie Harner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Thrift		Address Same as Item #2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 199.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Cardiac Arrestive Failure (c) DUE TO General Debility due to CA? INTERVAL BETWEEN ONSET AND DEATH 13 hrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Neural Effusion - Alleviates CA? abdominal AP?		20c. TIME OF INJURY Month, Day, Year Hour o. m. 20d. INJURY OCCURRED p. m. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from act , 19 49 , to 31 July, 1957 , that I last saw the deceased alive on 30 July, 1957 , and that death occurred at 9A.M. from the causes and on the date stated above. ACTUAL SIGNATURE P.B. Murphy, M.D.		ADDRESS (Street, city or town, state) Bethesda Maryland		DATE SIGNED 31 July 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/57		22c. NAME OF CEMETERY OR CREMATORIUM Darnestown Ch. Cem		22d. LOCATION (City, town, or county) (State) Darnestown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR 8-1-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

BUREAU V.

AUG 5 19

REGREVILLE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07714 CERTIFICATE OF DEATH

07707
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Tennessee		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 91 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chattanooga				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 709 Vine Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Eugene	Middle Franklin	Last TURNBURKE	4. DATE OF DEATH July	Month July	Day 10	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8-22-91	9. AGE (In years lost birthday) 65 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Eugene Clary TURNBURKE				14. MOTHER'S MAIDEN NAME Martha BEANE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I & II		17. INFORMANT unknown		Address Official Navy Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Adenocarcinoma rt. kidney and adrenal</i> UNKNOWN DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Arlington	(County) Arlington	(State) Virginia
21. I certify that I attended the deceased from 10 April 1957 , to 10 July 1957 , that I last saw the deceased alive on 10 July 1957 , and that death occurred at 8:40A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Melvin Rotner</i> M.D. U.S. Naval Hospital, Bethesda, Md. 7-12-57 DATE SIGNED								
PHYSICIAN'S NAME (Type) Melvin Rotner, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-15-57	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE J. J. O'Leary #324 — CHAMBERS, 3702 "M" ST., N.W. Washington, D. C.				24. REC'D BY REGISTRAR George P. Garey REGISTRAR'S SIGNATURE DATE 7-12-57				

RECEIVED
BUREAU V. S.

JUL 15 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07708

07715

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>MONTGOMERY</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. LENGTH OF STAY IN 1b <i>5 days.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X - KENSINGTON</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>4108 EVERETT ST.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>MARY EMMA TURNER</i>		First	Middle	Last	4. DATE OF DEATH <i>JULY 2 1957</i>	Month	Day	Year	
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>AUG 4 - 1870</i>	9. AGE (In years last birthday) <i>86 yrs.</i>	10. IF UNDER 1 YEAR Months <i>16</i>	Days <i>28</i>	Hours Min. <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWIFE</i>		11. BIRTHPLACE (State or foreign country) <i>NEW JERSEY</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>			
13. FATHER'S NAME <i>FREDERICK NORLEY TURNER</i>		14. MOTHER'S MAIDEN NAME <i>CLARA NESBITT</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>MRS EVELYN TURNER LANE (DAUGHTER)</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>440.0</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>		Acute Myocardial Failure		INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>			
(b)		DUE TO		Arteriosclerotic Heart Disease					
(c)		DUE TO		Arteriosclerosis, generalised					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>1. Neoplastic Disease of Stomach - Type undetermined.</i>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>(None)</i>							
20c. TIME OF INJURY Hour a. m. p. m.		Month <i>July</i>	Day <i>2</i>	Year <i>1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>3921 Ingomar St. N.W. Wash. 15 D.C.</i>	20f. (City or town) <i>3921 Ingomar St. N.W. Wash. 15 D.C.</i>	(County) <i>Wash. D.C.</i>	(State) <i>D.C.</i>
21. I certify that I attended the deceased from <i>July 2, 1957</i> , to <i>July 2, 1957</i> , that I last saw the deceased alive on <i>July 2, 1957</i> , and that death occurred at <i>1:55 P.M.</i> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <i>3921 Ingomar St. N.W. Wash. 15 D.C.</i>									
DATE SIGNED <i>7-10-57</i>									
ACTUAL SIGNATURE <i>Stewart Clapp</i>		M.D. <i>3921 Ingomar St. N.W. Wash. 15 D.C.</i>							
PHYSICIAN'S NAME (Type) <i>Stewart Clapp</i>									
22a. RURAL CREMATION, REMOVAL (Specify) <i>Bur-Transit 7/5/57</i>		22b. DATE THEREOF <i>7/5/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Fairmount Cemetery</i>		22d. LOCATION (City, town, or county) <i>Fairmount, Newark, N.J.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i>		ADDRESS <i>Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR <i>7-10-57</i>		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>			

BUREAU V. A

JUL 12 1957

REGEVIEW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07709

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 223

FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

TO ITS GRANTED AGENT: This certificate should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN lb

4 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington San & Hosp.

3. NAME OF
DECEASED
(Type or print)

William

First

Middle Vandiver

Last

4. DATE
OF
DEATH

July

26

19 57

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

April 25, 1894

9. AGE (in years
last birthday)

63 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or Foreign country)

Labor

13. FATHER'S NAME

John J. Vandiver

1

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Unknown

14. MOTHER'S MAIDEN NAME

Nettie

8477 Window

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

830X

DUE TO

Thoracio Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATHConditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

(b)

DUE TO

(c)

Crushed Chest

4 hrs.

PART II. OTHERS SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20c. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

Backed over by truck

20c. TIME OF INJURY
Hour 10:40 Month Day, Year
10:40 a.m. 7/25/57 1920d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, Farm,
Factory, street, office bldg., etc.)
Construction job20f. (City or town)
Adelphia(County)
P.G.(State)
Md.21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner ACTUAL
SIGNATURE

Frank J. Broschart

MD CHIEF MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S
NAME (Type)

Frank J. Broschart

ASSISTANT MEDICAL EXAMINER 22a. CEREMONY OR
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

7/25/57

(State)

July 29-57

Tuxedo

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

254 Carroll St E

Baltimore

24a. REC'D BY REGISTRAR

Wilma Dodd

DATE

7/27/57

Signature

Signature

RECEIVED
BUREAU V. S.

JUL 29 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 by _____ retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07710

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		07716		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oney</i>		c. LENGTH OF STAY IN lb <i>1 wk</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harmons,</i>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke grove Chronic Hosp</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First <i>James</i>	Middle <i>S. Nawter</i>	Last <i>Nawter</i>	4. DATE OF DEATH	Month <i>July</i>	Day <i>22</i>	Year <i>1957</i>						
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 22, 1878</i>	9. AGE (In years lost birthday) <i>79 yrs</i>	10. UNDER 1 YEAR IF UNDER 24 HRS Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>C.P.A in Govt</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>C.P. A</i>		11. BIRTHPLACE (State or foreign country) <i>Clifton Forge, Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>J. William Nawter</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Dew Scan-</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.							
17. INFORMANT <i>James S. Nawter</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Insanity (in coma.)</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>years</i>							
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</i>		(b) <i>Arteriosclerosis</i>				<i>years</i>							
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>1/5/57</i>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m. Not while of work <input type="checkbox"/> of work <input type="checkbox"/>			20d. INJURY OCCURRED White <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) <i>1</i>	20f. (City or town) <i>Santa Fe</i>	(County) <i>Howard Co.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>7/21/57</i> to <i>7-22-57</i> , that I last saw the deceased alive on <i>July 22, 1957</i> , and that death occurred at <i>11:15 PM</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Santa Fe</i>			DATE SIGNED <i>7/23/57</i>				
ACTUAL SIGNATURE <i>J.W. Bird</i>		M.D.											
PHYSICIAN'S NAME (Type) <i>J. W. Bird M.D.</i>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 25, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Zion</i>		22d. LOCATION (City, town, or county) <i>Highlands Howard Co., Md.</i>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. J. McDonald</i>		ADDRESS <i>Laurel, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 26 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Gertrude Lawlor</i>							

SUREAU Y.

JUL 26 1957

REGGIE EDE

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23 et

07586

0771-223

Reg. Dist. No.

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1, 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS 115 (4)
1 9/55

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jackson Park</i>		c. LENGTH OF STAY IN 1b <i>5 days.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Dwight D. Eisenhower Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jackson Park</i>	
3. NAME OF DECEASED (Type or print) <i>Joseph George Vieau</i>		First <i>Joseph</i>	Middle <i>George</i>
4. DATE OF DEATH <i>7-23-57</i>		Month <i>7</i>	Day <i>23</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>2-21-04</i>		9. AGE (in years last birthday) <i>53 yr.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Business Agent Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>	
11. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph R. Vieau</i>		14. MOTHER'S MAIDEN NAME <i>Mary Lindenborn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Res. Fam & Hosp - Decedent</i>		Address <i>—</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>420.0</i>			
(b) <i>Generalized arteriosclerotic heart disease</i>			
DUE TO (c) <i>and severe hypertension</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>331X</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>22 July, 1957</i> to <i>23 July, 1957</i> that I last saw the deceased alive on <i>23 July, 1957</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above			
ACTUAL SIGNATURE <i>Ernest E. Harmon</i>		ADDRESS (Street, city or town, state) <i>9301 Catesville Rd.</i>	
DATE SIGNED <i>—</i>			
PHYSICIAN'S NAME (Type) <i>Ernest E. Harmon M.D.</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Lucius Cemetery</i>	
22d. LOCATION (City, town, or county) <i>3701 Bladensburg Rd. - N.E.</i>		(State)	
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22f. DATE THEREOF <i>July 25 1957</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Johnson</i>		ADDRESS <i>1212 D.C. 25 Carroll St. N.W.</i>	
24. REC'D BY REGISTRAR <i>24 1957</i>		REGISTRAR'S SIGNATURE <i>John G. Johnson</i>	

BUREAU V.

JUL 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07712

07717 CERTIFICATE OF DEATH

Reg. Dist. No. 216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATS (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Montgomery MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Bethesda		15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR-INSTITUTION		e. STREET ADDRESS	
St. Lukes		Silver Spring 19911-T.D.A. Bldg.	
f. DATE OF DEATH		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
July 10 1957			
h. NAME OF DECEASED (Type or print)		First	Middle
IrvIng MARTIN		WEISSMAN	
i. SEX		j. COLOR OR RACE	
Male W		k. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
		l. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
m. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		n. KIND OF BUSINESS OR INDUSTRY	
Civil Engineer		Gvt	
o. BIRTHPLACE (State or foreign country)		p. AGE (In years lost birthday)	
N.Y.C.		53 yrs.	
q. CITIZEN OF WHAT COUNTRY?		r. IF UNDER 1 YEAR Months Days Hours Min	
U.S.A.			
s. FATHER'S NAME		t. MOTHER'S MAIDEN NAME	
Arthur Weissman		Emma Schreiber	
u. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		v. SOCIAL SECURITY NO.	
No		None	
w. INFORMANT		x. Address	
Mrs. J. D. Weissman - 911 Indiana		S. S. N. #	
y. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		z. INTERVAL BETWEEN ONSET AND DEATH 23 Days	
Coronary Thrombosis			
Due To			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
Due To			
(c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
aa. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		bb. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
cc. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		dd. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		ee. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
ff. (City or town)		(County) (State)	
gg. ADDRESS (Street, city or town, state)			
hh. DATE SIGNED			
ii. ACTUAL SIGNATURE		mm. 906 Colmore Rd 7/14/57	
jj. PHYSICIAN'S NAME (Type)		kk. Silver Spring Md	
ll. BURIAL, CREMATION, REMOVAL (Specify)		mm. DATE THEREOF	
Cremation		mm. 7/12/57	
nn. NAME OF CEMETERY OR CREMATORIAL		oo. LOCATION (City, town, or county)	
Fort Lincoln Crematory		oo. Prince Georges County, Md. (State)	
pp. FUNERAL DIRECTOR'S SIGNATURE		qq. REC'D BY REGISTRAR	
The S.H. Hines Co. 2901 14th St., N.W.		qq. DATE 7/12/57	
rr. REGISTRAR'S SIGNATURE		ss. BURIAL/CREMATION	
May Dandridge		Bridie Thompson	

KEGEIVEL
BURÉAU V. E.
UL 12 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17713

17718

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	c. LENGTH OF STAY IN 1b 404RS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 110 LEIGHTON AVENUE	d. STREET ADDRESS 110 LEIGHTON AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MARY JANE WELLINGTON	First	Middle	Lost
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 26, 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. TREASURY DEPT CLERICAL.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME, ORRISON, MONTGOMERY		14. MOTHER'S MAIDEN NAME, BONNIE MARY STUNKLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. NONE. 17. INFORMANT MR. WELLINGTON Address AS ABOVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO CARCINOMA BREAST WITH INTERVAL BETWEEN ONSET AND DEATH 5 YEARS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTASIS TO SPINE. - 1.5 MONTHS (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 13, 1957, to July 27, 1957, that I last saw the deceased alive on July 27, 1957, and that death occurred at 4:45 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James A. Roberts M.D. 8707 GEORGIA AVE SILVER SPRING MD 7/27/57			
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 31, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Mausoleum
22d. LOCATION (City, town, or county) Prince George's County, Md.		(State)	
22e. FUNERAL DIRECTOR'S SIGNATURE Frances E. Humphrey		24a. REC'D BY REGISTRAR DATE 3057	24b. REGISTRAR'S SIGNATURE Frances Deller
ADDRESS Silver Spring, Md.		ADDRESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 31 1957

Pittman

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07719

CERTIFICATE OF DEATH

07714

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 109 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. STREET ADDRESS 719 Hallwood Ave.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle (mn)	Last WILKES	4. DATE OF DEATH July 20 1957	Month July	Day 20	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 26 May 1895	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months 62	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frank WILKES		14. MOTHER'S MAIDEN NAME Nancy BEALE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I & II		17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of Right Kidney</i> DUE TO <i>with metastasis to brain and lymph nodes</i> INTERVAL BETWEEN ONSET AND DEATH <i>13 months approx</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I(a) <i>Left lobular pneumonia; Atherosclerosis</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. U.S. Naval Hospital, Bethesda, Md.		(City or town) (County) (State)	
21. I certify that I attended the deceased from 2 April 1957 to 20 July 1957 , that I last saw the deceased alive on 20 July 1957 , and that death occurred at 9:07 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 7-20-57							
ACTUAL SIGNATURE <i>Thirl E. Jarrett</i>							
PHYSICIAN'S NAME (Type) Thirl E. Jarrett, CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-24-57		22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.				ADDRESS REG'D BY REGISTRAR DATE 7-22-57 REGISTRAR'S SIGNATURE <i>Mary E. Parrelly</i>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V.

55 05 1957

REGELIVE

FOR STATE
HEALTH DEPT.

TO FULLY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATSM
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07715

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
3. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Summer</i>		c. LENGTH OF STAY IN 1b <i>3 yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>5005 Randall Lg (wash 16)</i>		d. STREET ADDRESS <i>5005 Randall Lg (wash 16)</i>	
e. NAME OF DECEASED (Type or print) <i>Karl Leigh Wilson</i>		e. DATE OF DEATH Month <i>July</i> Day <i>27</i> Year <i>1957</i>	
f. FIRST MIDDLE LAST <i>Karl Leigh Wilson</i>		f. AGE (In years at birthday) <i>65 yrs</i>	
g. SEX <i>Male</i>		g. COLOR OR RACE <i>White</i>	
h. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		i. DATE OF BIRTH <i>Apr 23 1892</i>	
j. WIDOWED <input type="checkbox"/>		k. DIVORCED <input type="checkbox"/>	
l. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>lawyer</i>		l. 10b. KIND OF BUSINESS OR INDUSTRY <i>Mid. Atl. Trans.</i>	
m. 11. BIRTHPLACE (State or foreign country) <i>N.Y.</i>		n. 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
o. 13. FATHER'S NAME <i>John Wilson</i>		p. 14. MOTHER'S MAIDEN NAME <i>Caroline Utter</i>	
q. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Tel. no. or unknown) <i>WW 1</i>		r. 16. SOCIAL SECURITY NO. <i>577-07-6983</i>	
s. 17. INFORMANT <i>Catherine Wilson (wife) Item 2</i>		t. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Exsanguination</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Ruptured Arteriosclerotic Aneurysm, Abdominal Aorta</i> , 1 hour DUE TO course lost (c)	
u. 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
v. 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
w. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
x. 20c. TIME OF INJURY Hour <i>o. m.</i> <i>p. m.</i>		y. 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
z. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>19</i>		aa. 20f. (City or town) <i>(County)</i> <i>(State)</i>	
bb. 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
cc. ACTUAL SIGNATURE <i>Frank J. Broschart</i>		dd. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ee. EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>		ff. DATE SIGNED <i>7-28-57</i>	
gg. 22a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>		hh. 22b. DATE THEREOF <i>7/31/57</i>	
ii. 22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National</i>		jj. 22d. LOCATION (City, town, or county) <i>Arlington, Virginia</i>	
kk. 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i>		ll. 24a. REC'D BY REGISTRAR DATE <i>7-29-57</i>	
mm. ADDRESS		nn. REGISTRAR'S SIGNATURE <i>Bennie M. Thompson</i>	

RECEIVED

JULG 1 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be reproduced for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 0772 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07716

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY	MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If int'l or on Residence before admission)
Montgomery			a. STATE Maryland	b. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Gaithersburg			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Gaithersburg. 24 Yrs.			Gaithersburg Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			R.F.D.3	
			DATE OF DEATH	Month Day Year
3. NAME OF DECEASED (Type or print)	First	Middle	July 20th 1957	
James		Leslie		
4. SEX	5. COLOR OR RACE	6. MARRIED	7. NEVER MARRIED	8. DATE OF BIRTH
Male	White	WIDOWED	DIVORCED	June 22-1933
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Tool & Machinist		Mechanical Engineer		Berwood Md.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
James L. Wood		Helen E. Johnson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT
(If yes, give war or dates of service)		218-30-7926.		Lawrence F. Ege. Gaithersburg. Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERNAL BETWEEN ONSET AND DEATH		
976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		2 men.		
(b) DUE TO				
(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASIDE CONDITION GIVEN IN PART I (o)				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Hour 4:30 P.M. Month, Day, Year 7-20 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home - Gaithersburg, Montgomery, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John G. Ball</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) John G. Ball		DATE SIGNED 20 July 1957		
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 7-23-57		22c. NAME OF CEMETERY OR CREMATORIAL Massanutten
22d. LOCATION (City, town, or county) Woodstock, Va.		24a. REC'D BY REGISTRAR DATE 7-23-57		
23. FUNERAL DIRECTOR'S SIGNATURE Dellinger & Son Funeral Home Va,		24b. REGISTRAR'S SIGNATURE Abraham G. Cooke		

RECEIVED
MAY 29 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07718.

07587

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 1b <i>23 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>34 Hickory Avenue</i>		d. STREET ADDRESS <i>134 Hickory Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>GERTRUDE</i>	Middle <i>LEE</i>	Last <i>WOODIN</i>
4. DATE OF DEATH <i>July 17 1957</i>	Month <i>July</i>	Day <i>17</i>	Year <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>January 8, 1871</i>
9. AGE (In years from birthday) <i>86 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. Govt Clerk (retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Government</i>	
11. BIRTHPLACE (State or foreign country) <i>Concord, New Hampshire</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Simeon F. Woodin</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Lee Utley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>153-00-0000</i>	
17. INFORMANT <i>Mrs. Grace W. Van Allen, same as #2.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cartharoma of Ileocecal Region</i> DUE TO 153X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Apr. 30</i> , 1957, to <i>July 17</i> , 1957, that I last saw the deceased alive on <i>July 16</i> , 1957, and that death occurred at <i>6105 N St</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>D.B. Little</i>	ADDRESS (Street, city or town, state) <i>6911 5th St NW Washington 12 DC</i>		
PHYSICIAN'S NAME (Type) <i>A. B. Little MD</i>	DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>July 19, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>	22d. LOCATION (City, town, or county) (State) <i>Prince George's Co. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters, 254 Carroll St NW D.C.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>7/19/57</i>	24b. REGISTRAR'S SIGNATURE <i>J. Wilson Dodd</i>

RECEIVED
BUREAU V. S.

JUL 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07722

CERTIFICATE OF DEATH

07719

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 174 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1200 East Princess Ann Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Fannie	Middle May	Last Worrell	4. DATE OF DEATH July 17, 1957	Month July	Day 17	Year 1957
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 28, 1917	9. AGE (In years lost birthday) 39 yrs.	IF UNDER 1 YEAR Months 39	IF UNDER 24 HRS. Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ernest Smith		14. MOTHER'S MAIDEN NAME Bulah Perry					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple intracranial abscess & infarcts DUE TO 227X INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) hemorrhage during post resection 6 months (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 596X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 24, 1957 , to July 17, 1957 , that I last saw the deceased alive on July 17, 1957 , and that death occurred at 11:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE David J. Kinsey		M.D.		DATE SIGNED 7/19/57			
PHYSICIAN'S NAME (Type) David J. Kinsey, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/19/57		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) Norfolk, Va	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Chinn		ADDRESS Arlington, Va		24a. REC'D BY REGISTRAR DATE 7-19-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

BUREAU V.

JULY 22 1957

RECEIVED